Iatrogenic Harm
Redress and the NHS

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THE DAY AFTER

IATROGENIC HARM – REDRESS AND THE NHS

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IATROGENIC HARM: REDRESS AND THE NHS

ABSTRACT

The thesis addresses how effectively or otherwise litigation and NHS complaints procedures redress 'harm' suffered by patients through treatment under the NHS. I argue that patients' entitlement to redress within the NHS is founded on corrective justice principles, requiring one who harms another without justification to indemnify the individual harmed. Entitlement is finite because the NHS is a communal enterprise with limited resources explicitly expected to be shared throughout the population. Accordingly, distributive justice must apply to monetary compensation. For my purposes, harm includes significant adverse events, even where the requirements for actionable negligence necessary to mount successful legal action are not met. The emphasis is on patients' access to justice, with account also taken of the toll on doctors under the present system.

I explore what patients seek from redress and the possible forms compensation may take. Litigation, curtailed by withdrawal of public funding, can only offer damages for loss. Complaints procedures theoretically offer, *inter alia*, explanations, apologies and undertakings to repair. Careful consideration of both systems reveals that in their present unconnected form, insufficient congruence obtains between what aggrieved patients with complex needs require and what they receive.

Lack of open disclosure of adverse events perpetuates power differentials between parties and adversely affects patients' abilities to seek appropriate redress. Analysis of constraints on disclosure highlights the nuanced communication that is necessary and the fears of legal ramifications which apologies engender. After discussing apology-protection legislation in other common law countries, I argue for the role that *full apologies* can play in explanation, communication and undertakings to repair, particularly in addressing intangible loss. I also argue that in a universal health service, non-pecuniary losses should not be monetarily compensated because they are uncommodifiable and because of distributive justice demands. The thesis concludes with reflection on the prerequisites for a just and effective redress system.

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Although the subject matter of the thesis is about when medical matters go awry, this is not a reflection of my experience. It has been my good fortune to have learned from exemplary doctors. For many years I worked with Dr Dora Black, Consultant Psychiatrist (Child and Adolescent), who set the standard for excellent practice. Professors John Studd and Margaret Johnson, Dr Clive Malcolm Tonks, Dr Kevin Zilkha and the late Dr Isaac Kashi all combine compassion, humour and understanding with the highest professional standards. In this they represent the highest traditions of the original NHS.

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mysteries of Intellectual Property law with clarity and humour and Sandra, his very special wife, took up where George left off to see me through to the final thesis.

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TABLE OF ABBREVIATIONS

AC	Appeals Court
AHA	Area Health Authority
AJA	Access to Justice Act 1999
ATE	After The Event (Insurance)
AVMA	Action for Victims of Medical Accidents
BMA	British Medical Association
BSB	Bovbjerg, Sloan and Blumstein article Valuing Life and Limb
CDS	Criminal Defence Service
CFA	Conditional Fee Agreements
CHRE	Council for Healthcare Regulatory Excellence
CLAF	Contingent Legal Aid Fund
CLS	Community Legal Service
CMO	Chief Medical Officer (The Ombudsman)
CNST	Clinical Negligence Scheme for Trusts
CPR	Civil Procedure Rule
CQC	Care Quality Commission
ECHR	European Convention of Human Rights
ECT	Electroconvulsive Therapy (Electric Shock Treatment)
ECtHR	European Court of Human Rights
FRC	Funding Review Committee
GLO	Group Litigation Order
GMC	General Medical Council
HA	Health Authority
ICAS	Independent Complaints Advisory Service
LJ	Lord Justice
LSC	Legal Services Commission
MMR	Measles Mumps and Rubella
MOD	Ministry of Defence
MRSA	Methicillin-resistant Staphylococcus aureus
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICE	National Institute of Health and Clinical Excellence
NPSA	National Patient Safety Agency
NT	Northern Territory (Australia)
PALS	Patient Advice and Liaison Service
PI	Personal Injury
PIBA	Professional Insurance Brokers Association
PPO	Periodical Payments Order
PTSD	Post-Traumatic Stress Disorder
QC	Queen's Counsel
RLF	Retrolental Fibroplasia (Retinopathy of Prematurity)
SA	(in legal citations) South Africa
SC	(in legal citations) Supreme Court
UMHM	The University of Michigan Healthcare Model

Sir William Yelverton, Justice of the King's Bench, [1472], depicted in armour with coif, judicial mantle and collar of suns and roses; Yelverton, Norfolk.

INTRODUCTION

PURPOSE AND PLAN OF THE THESIS

> The Library at Night argues that the hankering for a flawless system remains a persistent Utopian hope of homo sapiens, the classifying animal.[1]

I. INTRODUCTION

At this time of political coalition and severe financial constraint,[2] it is particularly challenging to consider the vexed question of meaningful redress for patients injured in the course of medical treatment within the National Health Service.[3] In the euphoria of the inception of the NHS, little thought was given to who would be sued in case of medical negligence when things go wrong. I will argue that there is entitlement to redress within the NHS premised upon a theory of corrective justice which requires that somebody who has harmed another, albeit unintentionally but without justification, indemnify the other. However, the entitlement is finite. Because the NHS is a communal enterprise and there is an explicit expectation that the 'goods' (limited resources) will be shared throughout the population, distributive justice arguments serve to limit monetary compensation.

The thesis addresses how effectively or otherwise the civil justice system through litigation, and/or the NHS complaints procedures, provides redress for patients suffering iatrogenic harm in the course of treatment received under the aegis of the NHS.

The thesis begins with an exploration of the philosophical platform upon which entitlement to redress for iatrogenic harm rests. My argument will be that entitlement to redress is founded upon corrective justice principles. However, because I am looking exclusively at harm within a universal health service, principles of distributive justice are engaged in relation to financial settlement.

I continue by considering what patients seek from redress and what motivates them to choose between litigation and complaint. This is followed by an analysis of medical

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[1] A Manguel, *The Library at Night* (New Haven, Yale University Press, 2008) quoted in *The Independent*, 25 April, 2008.
[2] 'Austerity Britain' 2012.
[3] Hereinafter 'NHS'.

negligence litigation, which considers whether the requirement for successful litigation (including the issue of funding and the requirement for proving medical negligence) assists or hinders access to justice in law. The redress available through litigation is damages. I make a twofold argument that damages should only be available for pecuniary loss. This is because of the non-fungible nature of intangible loss and because of distributive necessity in a welfare medical system. I then turn to a critical overview of redress within the NHS. Here, I first consider the history of the NHS complaint processes and then analyse to what extent the current system addresses complainants' needs. I conclude that both the civil justice system and the NHS complaints processes, for different reasons, fall short of providing just redress for iatrogenic harm.

I conclude the thesis with consideration of how a more effective redress scheme could be achieved.[4] There are two proposals for fast-track low-value clinical negligence schemes: Lord Justice Jackson's proposals that the abandoned NHS Redress Act 2006 be resurrected;[5] and Lord Young's proposal that the Road Traffic Act fast-track scheme be extended to clinical negligence claims.[6] However, in the final chapter I concentrate most upon the role of apologies in the medical situation. Lack of disclosure of adverse events is a major stumbling block for iatrogenically harmed patients in both the litigation and complaints systems. I discuss factors that impede candour and I consider innovative programmes in common law countries which have apology laws and apology-protection laws in the medical context. It is to be hoped that more of the humane recommendations in *Making Amends*[7] will come to fruition.[8]

II. ARGUMENTS AND THEMES

A. The Problem

Modern healthcare is delivered in a highly complex, pressurised environment, often involving the care of seriously ill patients. More than in any other industry in which

[4] E Cave, 'Redress in the NHS' (2011) 27 *Professional Negligence* 3, 138-157 at 139.
[5] The Right Honourable Lord Justice Jackson, *Review of Civil Litigation Costs, Final Report,* (London, The Stationery Office, December 2009) ch 23, paras 7 and 8.
[6] HM Government, Lord Young, 'Common Sense, Common Safety: A report by Lord Young of Graffham to the Prime Minister following a Whitehall‑wide review of the operation of health and safety laws and the growth of the compensation culture' (London, The Stationery Office, October 2010), 23.
[7] Chief Medical Officer, *Making Amends: A Consultation Paper Setting out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (Crown Copyright, Department of Health, 2003) (hereinafter CMO, *Making Amends*).
[8] Cave (n 4), 140.

risks occur, healthcare is reliant on people, more often than on machines, to make decisions, exercise judgement, and execute the techniques which will determine the outcome for a patient.[9] In such circumstances, things can and do go wrong. Sometimes unintentional harm comes to patients as a result of a clinical decision or clinical procedure. The consequences may be very serious for the patient, his family and carers.[10] There are said to be about a million adverse clinical events each year, but only a few thousand clinical negligence claims, of which only a modest proportion show a sustainable cause of action resulting in an award or settlement.[11] Even accepting that an adverse event is not necessarily a breach of duty causing injury, the figures suggest that much negligence is not compensated and most cases of alleged negligence are not legally sustainable. There appears to be a mismatch between incidents of actual negligence and cases of alleged negligence.[12]

B. Claimants and Complainants: Both Short-changed?

In the Parliamentary debates involved with the passage of the NHS Redress Act 2006,[13] there was recognition of the problems of litigation: delay, limited access to justice, procedural complexity, low success rate and disproportionate legal cost.[14] It was also clear from the debates in both Houses that most patients who have suffered adverse events want an explanation, an apology where appropriate, and some mechanism to ensure that lessons are learnt and mistakes avoided in the future.[15] The reports of the Health Ombudsman and of the House of Commons Health Committee[16] emphasised the failings of the current NHS complaints procedures and the need for better communication and more effective redress for complainants.[17]

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[9] CMO *Making Amends* (n 7), 58**.**
[10] Ibid.
[11] MJ Powers, NH Harris and A Barton, *Clinical Negligence,* 4th edn, (Haywards Heath, Tottel Publishing Limited, 2008), Foreword.
[12] Ibid.
[13] Chapter 8 'NHS Redress Act 2006' below.
[14] Part II Medical Negligence Litigation: Chapter 3 'Funding Litigation': Chapter 4 'Proving Clinical Negligence' Chapter 5 'Causation' below.
[15] NHS Redress Bill Explanatory Note available at http://www.publications.parliament.uk/pa/cm200506/cmbills/137/en/06137x--.htm. See Chapter 2 'What Do Patients Seek From Redress?' below.
[16] A Abraham, *Listening and Learning*: the Ombudsman's Review of Complaint Handling by the NHS in England 2010-1; House of Commons Health Committee, 'Complaints and Litigation' Sixth Report of Session 2010-12, Printed 22 June 2011.
[17] Chapter 7 'History of NHS Complaints Processes – A 'Curate's Egg'? below.

Overall, I argue that there is an implicit ethos that patients who are harmed should be compensated but that there are inadequate mechanisms in place to facilitate this. My thesis concerns itself with how to achieve, as near as possible, full redress for iatrogenic harm. I will consider redress not simply by means of financial compensation[18] but in particular, I focus upon innovative redress for non-pecuniary harm by means of, *inter alia,* full apologies, relying on recent initiatives in Australia, Canada and the USA.[19] I place special emphasis on the real difficulties of the communication of bad news and analyse the constraints on candour in the absence of a legal duty of candour and even where apology-protection legislation exists. I will also argue that, particularly in the context of a universal health service, monetary compensation is not appropriate to redress non-pecuniary, uncommodifiable, loss. My argument is both philosophical and practical. Redress for iatrogenic harm needs to be broader than financial compensation and should also include the possibility of acknowledgement apology, correction and sanction. Most importantly, in all the studies cited, aggrieved patients and relatives wanted assurance that 'lessons would be learned' and adverse events would not be repeated.[20] Unfortunately, this is as yet an unrealised goal and systems for reporting adverse events in order to learn from them remain inadequate.

C. Implicit Assumptions

I have taken a broad definition of harm to include patients who have suffered a significant adverse event even if this falls short of the requirement of actionable negligence necessary to mount a successful legal action. The main emphasis is on patients and their access to justice, although account is taken of the toll on doctors under the present system.

The parameters of the debate in this thesis are constrained by several underlying assumptions. First, there is a presumption of an idealised model of a welfare state National Health Service. This assumes that *de facto* 'every penny spent on compensation is money that could otherwise be spent providing healthcare'.[21] This model throws into stark relief the problem of NHS resources being used to compensate

[18] Chapter 6 'Damages' below.
[19] Chapter 9 'Effective Redress and the Role of Apologies' below.
[20] Chapter 2 'What Do Patients Seek From Redress?' below.
[21] CMO, *Making Amends* (n 7), 111.

for non-pecuniary loss.[22] Second, it will be argued that non-pecuniary loss is uncommodifiable[23] and needs addressing, apart from financial compensation.[24] Third, there is a preference towards the model of corrective justice, to be understood as the view based on Aristotle's *Nicomachean Ethics* that individual moral rights are the foundation on which negligence law is based.[25] Corrective justice theory focuses on the connection between law and morality by arguing that there is a specific obligation resting on the individual who causes harm to correct that harm in some way.[26] Fault is central to negligence law because of its connection to moral responsibility[27] and, in particular, to personal responsibility. There is an emphasis on the transactional nature of the relationship between victim and wrongdoer.[28] Thus, although negligence law is outcome-responsibility based[29] the fault principle (based on the act itself) is what operates to determine who should compensate.[30] I find the corrective justice model so compelling because essentially the paradigm of clinical negligence concerns interaction between two individuals, the doctor and the patient.[31] Corrective justice theory equates best to the moral hinterland of apologies. The moral account of apology focuses centrally on *what was done*, being the moral wrongfulness of the perpetrator's action, while tort law focuses on *outcome-responsibility*. One of the reasons I will argue against a distributive justice model, which more easily accepts the idea of no-fault schemes, is on the basis that it neglects the necessary moral recognition of responsibility.[32]

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[22] This model also puts to one side the real world where NHS funding gets diverted, eg 'Accenture, the leading management and technology consulting firm, announced a provision for a further £450 million of losses against its contract to deploy IT systems on behalf of the English NHS.' The Guardian 29 March 2006.

[23] See M Radin, *Contested Commodities* (Cambridge Massachusetts, Harvard University Press, 1996).

[24] See Chapter 6 'Damages' for discussion of the role of damages for non-pecuniary loss.

[25] P Vines, 'The Power of Apology: Mercy, Forgiveness or Corrective Justice in the Civil Liability Arena?' (2007) 1 *Public Space: The Journal Of Law And Social Justice* 1, 13. Note: corrective justice as opposed to distributive justice. See Chapter 1 'Corrective Justice and Entitlement to Redress within the NHS' below.

[26] S Perry, 'The Moral Foundation of Tort Law' (1992) 77 *Iowa Law Review* 449 and E Weinrib, 'The Special Morality of Tort Law' (1989) 34 *McGill LJ* 403 for accounts of corrective justice theory.

[27] See Vines (n 25), 14 fn 63 for further accounts of corrective justice theory.

[28] E Weinrib, *The Idea of Private Law*, (Cambridge Massachusetts, Harvard University Press, 1995), 57.

[29] This represents the view that the wrongdoer must be responsible for the outcome of his actions rather than the actions themselves.

[30] Perry (n 26), 497.

[31] Admittedly the paradigm may be deceptive. One of the dyad may turn out to be a large corporation/ hospital.

[32] Chapter 1, 'Corrective Justice and Entitlement to Redress within the NHS' herein.

D. Civil Litigation and the NHS Complaints Procedure: The Patient's Dilemma: Which or Both?

The legal and the Health Service routes to justice are quite different. The former offers damages, the latter explanations, apologies where appropriate, and undertakings to repair. Damages operate as compensation, as a marker of wrongdoing and as acknowledgement that redress is needed. Damages also address needs and this might be regarded as their most significant aspect. Explanations and apologies act as different types of reparation. They address the emotional and moral pain suffered by the victim and his family. However, as will be shown, access to either system presents difficulties.[33] Patients and their families may have to endure repeated hearings in their efforts to obtain information and justice.[34] Until recently, the two systems have been mutually exclusive in that recourse to the law barred one from using the NHS complaints procedure. The NHS Redress Act 2006, intended to provide a framework for the resolution of clinical negligence disputes by combining features of the legal and healthcare mechanisms, is not yet fully functioning but is under consideration.[35] I will argue that both the legal and the NHS systems, while offering some remedies, have their drawbacks. This is especially true for those seeking clarification of the adverse event. Here again, my arguments for facilitating full apologies become relevant.

E. The Import of Redress: Pecuniary and Non-Pecuniary Losses

Apposite redress for harm incurred through clinical negligence should accord with the particular harm incurred, namely, pecuniary and non-pecuniary loss. The legal route to redress is quintessentially about obtaining damages;[36] clearly, for pecuniary losses sustained, receiving payment is essential and congruent. As to who should pay, this is addressed when we consider notions of corrective justice. Some claims can only be put right by the harm-doer, as when an apology is claimed. In other circumstances, such as where the claim is for money, this can be satisfied by someone else, such as the

[33] Chapter 3, 'Funding Litigation' and Chapter 7, 'History of NHS Complaints Processes – A 'Curate's Egg'? herein.
[34] Chapter 7, 'History of NHS Complaints Processes – A 'Curate's Egg'? herein.
[35] Chapter 8, 'NHS Redress Act 2006 – A Lost Opportunity' herein. Note: although in *Making Amends* (n 7), it was mooted that a duty of candour might be imposed in the forthcoming NHS Redress Act 2006, this did not materialise. M Brazier, and E Cave, *Medicine, Patients and The Law*, 5th edn (Harmondsworth, Penguin, 2011), 270.
[36] Although claimants may indicate other motives, the redress available at the end of the day is financial. See Chapter 6 'Damages'.

insurer.[37] However, just as patients can experience diverse avoidable outcomes of care,[38] so the effects of a serious adverse and unexpected outcome of care go beyond the physical injury itself. The psychological and social impact of an adverse event can include anxiety, depression, and fear of future treatment, disruption to work and family life and, in the worst case, bereavement. This leads us to the question of redress for non-pecuniary or intangible losses, which are, by definition, non-fungible. If, in tort law, damages are paid to try 'as far as money can' to put the victim of harm back to his 'pre-tortious state',[39] what happens when there is no congruence between the desired relief by the claimant and the compensation available?

F. Effective Redress and the Role of Apologies

Medico-legal disputes are costly to both doctors and patients, not only in terms of money, but, more significantly, in the emotional toll on all parties. I argue that the current civil justice system and the NHS complaints processes are failing the very people they are designed to assist. With the withdrawal of legal aid for clinical negligence cases,[40] access to justice through litigation will be severely curtailed and there will be increasing pressure on achieving less costly litigation, perhaps through a form of fast-track scheme for low-value clinical negligence cases.[41] There will also be more pressure on the NHS procedures. In the final chapter in this thesis,[42] I address the issue of how to achieve an effective, streamlined redress system. Looking to the future, it will be instructive to monitor how well the redress scheme in Wales and the possible no-fault system in Scotland serve iatrogenically harmed patients. I start with a small but significant first step advocating a *full apology* system which would empower patients through knowledge to make informed decisions on how to achieve just redress. This thesis takes into account developments in the law up to the end of July 2012. Throughout this thesis, all emphasis is mine unless explicitly mentioned otherwise.

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[37] See Vines (n 25), quoting A Honoré, 'The Morality of Tort Law' in D Owen, *Philosophical Foundations of Tort Law,* (Oxford, Clarendon Press, 1995), 79.

[38] For example, as a result of: a sudden catastrophic event; being treated by a service performing sub-optimally; suffering a recognised complication of care; or failing to gain access to a service using evidence-based best practice.

[39] S Deakin, A Johnston and B Markesinis, *Markesinis and Deakin's Tort Law* 6th edn (Oxford, Oxford University Press, 2008), 951.

[40] Legal Aid, Sentencing and Punishment of Offenders Act 2010-2012 Part 2 received Royal Assent on 1 May 2012. See also Chapter 3 'Funding Litigation' below.

[41] Cave (n 4), 154.

[42] Chapter 9, 'Effective Redress and the Role of Apologies' below, outlined above in the introduction to this chapter.

III. THE STRUCTURE OF THE THESIS

The title *The Day After* reflects my interest in the consequences for all parties after a patient suffers iatrogenic harm in the course of treatment within the NHS. The fact that the treatment occurs under the aegis of a universal healthcare setting is significant, because the demands of the general population as well as the treated patients must be taken into account. In the sphere of clinical negligence, the stakes are high for both doctors and patients. Doctors have been found to have intense negative emotional responses such as stress, anxiety and anger, as well as guilt and shame, after receiving complaints.[43] Patients have to live with the consequences of the adverse event and realistically cannot be restored to their pre-tortious state. The thesis addresses the moral imperative of redress for the harm, the mechanisms currently in place in the civil justice and NHS systems for compensation in its broadest sense and the possibility of improvement of both systems in order to achieve a more positive outcome where learning from mistakes can occur.

The thesis consists of three parts: *Part I, Introduction*, the philosophical basis of redress for injured patients; *Part II, Medical Negligence Litigation* – with chapters on *Funding Litigation, Proving Clinical Negligence, Causation and Damages* – addresses the issue of what hinders access to redress in law; and *Part III, Redress within the NHS,* analyses the redress available though the NHS complaints procedures and includes chapters on the *History of NHS Complaints Processes – A Curate's Egg?, the NHS Redress Act 2006 – A Lost Opportunity,* and a final chapter covering the constituents of a system offering *Effective Redress and the Role of Apologies.* The thesis ends with a concluding summation of the key arguments.

[43] W Cunningham, S Dovey, 'The Effect on Medical Practice of Disciplinary Complaints: Potentially Negative for Patient Care' (2000) 113 *New Zealand Medical Journal* 1121, 464-7 at 465.

PART I INTRODUCTION

Chapter 1 Corrective Justice and Entitlement to Redress Within the NHS

In this opening chapter, I discuss the legal and philosophical basis for patients' entitlement to redress within the NHS. This is framed in the language of patients with rights rather than as passive beneficiaries. Liability for iatrogenic harm is derived from the concept of fault.[44] After consideration of the importance of the idea of fault, I discuss the philosophical basis of the imperative to make good by reference to theories of corrective and distributive justice, using the case of *MacFarlane v Tayside*[45] as an example. My argument is that while corrective justice underpins the necessity of full compensation for pecuniary loss, when it comes to damages for non-pecuniary loss, other factors come into play. These include the NHS's responsibility to the wider community based on notions of distributive justice and the non-fungible nature of intangible losses. The discussion is limited to the special circumstances inherent in a national health service with a mandate to treat the citizenry within the limits of a constrained budget. The chapter concludes with thoughts about alternative redress for non-pecuniary loss. This includes exploring what is available through the NHS complaints processes and *full apologies,* and this search is a constant theme throughout the thesis.

Chapter 2 Redress for Iatrogenic Harm: What Patients Seek: Claimants and Complainants

The question of what iatrogenically injured patients and their families might seek from redress is a complicated one. There is no solution offering *restitutio in integrum*; therefore most forms of redress are rendered second best from the start. Historically four themes have been mooted: restoration, including financial compensation or another intervention to 'make the patient whole again'; correction, such as a system change or competence review to protect future patients; communication, which may include an explanation, expression of responsibility, or apology; and sanction, including

[44] P Cane, *Atiyah's Accidents, Compensation and the Law* 7th edn (Cambridge, Cambridge University Press, 2006) 421.
[45] *MacFarlane v Tayside* [2002] 2 AC 59. Note: There would appear to be two spellings of the Claimants' surname in the literature; the name McFarlane is rendered as MacFarlane in the Appeals Court case of 2002. Both spellings have been used in this thesis.

professional discipline or another form of punitive action.[46] More recently these notions have been considered in more nuanced ways.[47]

Due to the increasing sophistication of medical law and the Human Rights Act (hereinafter 'HRA') 1998, there are now a myriad of initiatives designed to address the 'tangle of motives behind a patient's or family's decision to take legal action following medical injury, money only representing one of them'.[48]

In this chapter, I address what is known about the motivations of patients who suffer an adverse event, why some become complainants and others claimants[49] and why some choose not to sue.

A major stumbling block for patients and families who suspect iatrogenic harm is the lack of honest information about adverse events. I analyse the lack of open disclosure, apologies and communication and consider the impediments to open disclosure from the medical providers. I discuss recent initiatives in England aimed at facilitating open disclosure, legal duty of candour and incidence reporting. I set out what patients might wish for redress. In the final chapter of the thesis,[50] I evaluate the *expectations gap* between what complainants/claimants want and what they in fact get out of the redress processes.[51]

Unfortunately, except for low-value claims,[52] there is as yet no integrated response system to address the wishes of claimants, both financial and otherwise. This chapter lays the foundation for the rest of the thesis,[53] which analyses redress available to victims both through the English legal system and the extralegal methods of pursuing

[46] M Bismark and E Dauer, 'Motivations for Medico-Legal Action – Lessons From New Zealand' (2006) 27 *The Journal of Legal Medicine* 55. Issues regarding professional sanctions and discipline will be addressed in Part III Redress within the NHS below.
[47] M Bismark, MJ Spittal, AJ Gogos, RL Gruen, DM Studdert, 'Remedies Sought and Obtained in Healthcare Complaints' (2011) 20 *British Medical Journal Quality and Safety* 806-810 and EA Dauer, 'Medical Injury, Patients' Claims and the Effects of Government Responses in Anglo-American Legal Systems' (2011) 20 *British Medical Journal Quality and Safety* 735-737.
[48] Bismark and Dauer (n 46).
[49] Bismark et al (n 47).
[50] Chapter 9 'Effective Redress' below.
[51] Bismark et al (n 47).
[52] Clinical negligence claim worth less than £1,000 *small claims track* should not result in proceedings. Brazier and Cave (n 35), 228.
[53] Themes addressed in this chapter will be expanded upon throughout the thesis.

complaints through the English NHS structures.[54] I will argue that apart from pecuniary loss, restoration through monetary means is illusory. Therefore within the strictures of a universal health service, both the needs of patients and their families and the demands of distributive justice are better served by improved extralegal initiatives.

PART II MEDICAL NEGLIGENCE LITIGATION

This part of the thesis addresses the legal route to justice.[55] I begin with the critical issue of the constraint on *access to justice* for iatrogenically harmed patients, now that clinical negligence cases have been removed from the scope of legal aid.[56] The *funding* for this litigation now depends upon the use of conditional fee agreements, and I analyse their operation. I then turn to the burden upon the claimant of *proving clinical negligence*; first *duty and breach* and then *causation*. While proving duty of care is not a problem in most instances, proving breach of duty is more difficult. I discuss the *Bolam* test and the extent to which *Bolitho* has given the courts more leeway in critical analysis of the reasonableness of the medical standards. In addition, I consider the role and function of expert witnesses.

The next chapter is concerned with the major hurdle of *proving causation*. I include discussion of *Chester v Afshar*,[57] a *failure to warn case*, framed in causation in order to effect justice and protect patients' autonomy and rights.

This part concludes with a chapter on *damages* – the sole redress available through litigation. I consider the symbolic meaning of damages as compensation for pecuniary loss and as inappropriate redress for non-pecuniary loss. I also address psychiatric harm and the courts' unease with the concept of pure psychiatric harm and the restrictive rules limiting the class of claimants.

In considering damage arising from iatrogenic harm I contrast the approaches of the English and Australian courts[58] to the question of whether or not compensation should

[54] Where applicable, references will be made to initiatives in other common law jurisdictions.
[55] Part III will address Redress within the NHS.
[56] Legal Aid, Sentencing and Punishment of Offenders (n 40), See Chapter 3 'Funding Litigation' which includes discussion of recent legal aid for clinical negligence cases.
[57] *Chester v Afshar* [2005] 1 AC 134, [2004] UKHL 41 Hereinafter *Chester*. Full analysis of medical law regarding consent to treatment is outwith the remit of this thesis.

be paid for the maintenance of a healthy child who was born as the result of negligent advice following a sterilisation operation.[59]

Chapter 3: Funding Litigation

In this chapter, I consider whether the arrangements, both extant and projected, for funding clinical negligence actions assist or adversely affect access to justice. At present,[60] clinical negligence actions may be funded by legal aid, conditional fee agreements (CFAs) and several other arrangements. For present purposes, I will be focusing on funding through legal aid, conditional fee ('no win, no fee') agreements, insurance and costs. Reform of legal aid is on the Government's agenda with the publication of the consultation documents: *Proposals for the Reform of Legal Aid in England and Wales*[61] and *Proposals for Reform of Civil Litigation Funding and Costs in England and Wales: Implementation of Lord Justice Jackson's Recommendations.*[62] It is proposed that 'all clinical negligence cases be excluded from civil legal aid because there is a viable alternative source of funding in CFAs'.[63] However, recognising that some individual cases will continue to require public funding even once they are removed from its scope, it is proposed that a power to grant legal aid in certain circumstances be retained.[64] I analyse the Government's rationale and justification for the use of legal aid and the cases meriting exception. At the conclusion of the chapter, I present arguments challenging the assumption that access to justice would not be adversely affected by this change. Access to justice has two aspects: the availability of legal representation in the civil justice system; and access to redress through extralegal routes. The challenge of widening access to justice is to address both these aspects in a financially viable way.[65]

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[58] JK Mason, 'A Turn-Up Down Under: *McFarlane* in the Light of *Cattanach*' (2004) 1 *Scripted* 1. The High Court rejected the House of Lords decision in *McFarlane*.
[59] *McFarlane v Tayside Health Board* [2000] 2 AC 59. See Chapter 1 'Corrective Justice and Entitlement to Redress within the NHS' for discussion of *McFarlane* and distributive justice arguments against recovery for the maintenance of a healthy child after negligent advice.
[60] Written just before the Legal Aid, Sentencing and Punishment of Offenders Act (n 40) received Royal Assent in May 2012. Chapter 3 'Funding Litigation' includes discussion of recent legal aid available for clinical negligence cases**.**
[61] *Proposals for the Reform of Legal Aid in England and Wales*. www.justice.gov.uk/consultations/legal-aid-reform-151110.htm. Any changes to legal aid are unlikely to be implemented before 2012 at 4.8.
[62] See:http://www.justice.gov.uk/consultations/Jackson-review-151110.htm.
[63] *Proposals* (n 61) at 4.166.
[64] Ibid. at 1.11.
[65] Powers, Harris and Barton (n 11), ch 11 'Funding Clinical Negligence Claims' Introduction at 249.

Chapter 4 Proving Clinical Negligence, Duty of Care and Breach of Duty

This part of the thesis focuses on the response of the civil justice system to actions for clinical negligence.[66] Having considered the funding difficulties faced by would-be claimants and the negative effect financial constraints have on access to justice,[67] in this and the next chapters I concentrate on the legal rules and requirements governing proof of clinical negligence. In particular, I consider whether the requirement for the claimant to prove the elements of any successful negligence claim acts as a hindrance to obtaining redress. I consider cases associated with medical treatment in one form or another. There has been a parallel series of cases of alleged negligence arising before treatment started. These cases are based on the right of the patient to make an informed choice regarding treatment. Although the principles underlying the tort of negligence are similar in both situations, the latter have developed a jurisprudence of their own which is outwith the remit of this chapter, and the chapter therefore confines itself to discussion of medical misadventure.

Clinical negligence is the principal action by which patients seek compensation for injuries caused within the NHS. The only other action which features to any extent is battery.[68] Claims for damages generally arise out of treatment or care to which the patient has consented, but which went wrong or did not produce the desired or expected outcome. The essence of the patient's claim is that the doctor was negligent in that he breached his duty to exercise reasonable care and skill in diagnosing, advising or treating the patient. Medical negligence is a specific form of negligence liability in the professional context.[69] A patient may have an action for breach of contract, in the tort of negligence[70] or for misrepresentation.[71]

I briefly explore problems regarding establishing the existence of a duty of care, where liability falls and the question of how far that duty extends. I then turn to the question of

[66] Part II Medical Negligence Litigation.
[67] Chapter 3 Funding Litigation.
[68] See I Kennedy, A Grubb, J Laing, and J McHale, *Principles of Medical Law,* 3rd edn (Oxford, Oxford University Press, 2010), ch 8.
[69] See Powell, J and Stewart, R (eds), *Jackson and Powell on Professional Negligence* 6th edn, (Andover, Sweet & Maxwell, 2007), with cumulative supplements.
[70] See Kennedy et al (n 68), 135 fn 19. Other actions may include false imprisonment or battery.
[71] Ibid, 135 fn 20. Under the common principle in *Hedley Byrne & Co Ltd v Heller & Partners Ltd* [1964] AC 465, or under the Misrepresentation Act 1967, where the patient has been induced to enter into a contract for the provision of medical services.

proving that there has been a breach of that duty. I consider the issues arising from the use of the *Bolam*[72] standard and the impact of the *Bolitho*[73] 'gloss'[74] on the assessment of medical breach. Discussion then focuses on the role of expert medical opinion in defining the appropriate standard of care. I touch upon the complexity of the role of the expert witness and note the decision of the Supreme Court in *Jones v Kaney*[75] overturning the long-standing rule that expert witnesses are immune from liability for damages to parties that have engaged them and to whom they owe a duty of care. I briefly delineate the role guidelines play in setting the requisite standard and raise the vexed question of the relevance of resources in framing NHS institutional liability.[76] I conclude by considering how the rules for establishing medical negligence, in particular the rules about establishing breach of duty, affect a claimant's access to justice via the civil litigation system.

Chapter 5 Causation

The true battleground in many clinical negligence cases is not breach of duty at all but causation.[77] Clinical negligence cases usually involve claimants who, by definition, were ill or injured before the treatment was given or sought and, by the very nature of their complaint, are ill or injured at the end of the process. Demonstrating the causation of the particular injury or illness complained of to the requisite legal standard can be of the utmost medical and legal complexity.[78] Having addressed the issues of when a duty of care arises and whether there has been a breach of that duty, I come to the most problematic aspect of a patient's claim. He must show that his injury, his worsened or unimproved condition, was caused by the doctor's negligence. Clinical negligence claims have special difficulties not only because of the vagaries inherent in illness and treatment but also the differences between scientific and legal approaches to the problem of causation.

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[72] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
[73] *Bolitho v Hackney Health Authority* [1998] AC 232.
[74] R Mulheron, 'Trumping Bolam: A Critical Legal Analysis of Bolitho's "Gloss"' (2010) 69 *Cambridge Law Journal* 3, 609-638.
[75] *Jones v Kaney* [2011] UKSC 13, [2011] All ER (D) 346 (Mar).
[76] J Beswick, 'A First Class Service? Setting the Standard of Care for the Contemporary NHS' (2007) 15 *Medical Law Review* 2, 245.
[77] P Balen, *Clinical Negligence* (Bristol, Jordans Publishing Limited, 2008), 187.
[78] Ibid.

In order to put the problems in proving causation into context, I start this chapter with a brief comparison between the scientific and legal approaches to evidence of causation. I then present the legal approach to determining causation. Causation of primary injury at the liability stage may take a number of forms: classical causation, other forms of causal connection which do not depend on a comparison, such as 'material contribution' and causation in the rare claims where the analysis of the causation of damage departs from a strict approach which would leave the claimant unable to prove damage.[79] These approaches address the question of whether the patient can convince the court that it was the relevant negligence which caused his injury, rather than the progress of his original disease or condition. Here, the court, in determining what did happen, is dealing with past fact and decides on the balance of probabilities.[80]

There is another class of cases that addresses a different question. How should courts proceed when the essence of a claim is not that clinical negligence caused any fresh or additional injury to the patient, but that negligence deprived him of the chance of full recovery from his original disease or condition? These cases, known as *loss of chance cases*, are about future events.[81] The patient must advance evidence showing that it is more likely than not that the defendant's negligence caused the injury of which he complains.

Having concluded discussion of *proving liability*, I turn to the question of damages.

Chapter 6 Damages

This is the concluding chapter of the section of the thesis concerned with medical negligence litigation. This chapter on damages[82] is the cornerstone of a thesis concerned with redress for negligently inflicted personal injury in clinical negligence suits. Redress via the civil litigation route is then contrasted with the possibilities of redress offered through the National Health Service schemes, which will inform the second part of the thesis.

[79] See the discussion of *Chester v Afshar* [2005] 1 AC 134 in Chapter 5 herein.
[80] Balen (n 77), 188.
[81] Brazier and Cave (n 35), 204.
[82] Interestingly, in five years of legal studies two hours were devoted to damages!

Selective subjects have been chosen which resonate with issues pertinent to the Health Service. The chapter begins with a discussion of theories of compensation, consideration of what damages are for and what they represent. The choice of model of corrective or distributive justice, deterrence, or retribution determines notions of entitlement to financial redress. This becomes particularly challenging when looking at the heads of claim pertaining to non-pecuniary loss and the use of monetary compensation for intangible losses. I concentrate on the theoretical and practical difficulties that claims for non-pecuniary loss represent. I discuss claims for wrongful death which encompass bereavement payments[83] and I touch upon relevant aspects of pecuniary loss. There follows a discussion of claims for psychiatric harm and/or injury which encompass both non-pecuniary and pecuniary losses.

I argue that in accepting corrective justice as my preferred model, I have no quarrel regarding patients' *entitlement* to full compensation for both pecuniary and non-pecuniary loss. However, mindful that there are compelling competing calls on the NHS budget for treatment from other patients and members of the public I would limit compensatory damages to pecuniary loss. This is because the NHS is, by its nature, a communal enterprise and the arguments for distributive justice which focus on the just distribution of goods across the population are also legitimate. In addition to this pragmatic argument there is the theoretical one. Because, by its very nature, non-pecuniary loss is non-fungible, after reviewing academic and judicial attempts to place financial value on these losses in this chapter, I suggest alternative models for redress for this aspect of claims in the final part of the thesis.[84]

The issue of redress for pecuniary loss is less theoretically challenging but of immense importance to claimants. In the larger picture, a serious crisis looms from the very challenge of tort law, exemplified by clinical negligence claims, as a suitable method of compensating accident victims[85] in the modern welfare state.[86] There have been perceived medical indemnity insurance crises in Australia, New Zealand, the USA and England. I conclude with a brief review of their legislative responses to this.

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[83] As an exception to my argument against payment for non-pecuniary loss, I would keep the bereavement award.
[84] See Part III Chapter 9 'Effective Redress and the Role of Apologies'.
[85] For example, patients suffering iatrogenic harm.
[86] C Sappideen, and P Vines, (eds) *Fleming's The Law of Torts* 10th edn (Australia, Thomson Reuters (Professional) Ltd, 2011), 15.

PART III REDRESS WITHIN THE NHS

Here I analyse the redress available though the NHS complaints procedures namely: the History of NHS Complaints Processes – A Curate's Egg?, the NHS Redress Act 2006 – A Lost Opportunity, and a final chapter, Effective Redress and the Role of Apologies, which summarises the necessary elements for a just system that includes apologies.

Chapter 7 History of NHS Processes – A Curate's Egg?

The prior section of the thesis[87] was concerned with claimants obtaining financial recompense through litigation. This section is about redress within the NHS and focuses on non-litigious and non-financial remedies for alleged clinical negligence, in particular, the increasingly important NHS complaints procedures. Where financial compensation is barred by virtue of limitations on legal aid and civil law reform,[88] more pressure will be placed upon the complaints system and professional regulation to deliver appropriate sanction, communication and correction.[89] I argue that a well-functioning complaints system would offer a significant alternative route to access to justice for iatrogenically harmed patients. In the interests of integration, it could be envisioned that some appropriate financial compensation could be included in this system.

After preliminary discussion of the context within which medical errors occur, I touch upon the regulatory processes and investigative recourse available. This is followed by a detailed analysis of the history and working of the NHS complaints processes and the role of the Health Ombudsman.[90]

I show that in its present form and operation the complaints system falls far short of these aspirations. Ideally, the NHS complaints system was envisaged not as a fall-back when litigation was not possible but as an avenue to address different problems such as explanations of the adverse event and plans to avoid recurrence. I measure the current complaints system against the Ombudsman's essential elements for a just system of redress. I conclude with discussion of the recommendations of the House of Commons

[87] Part II Medical Negligence Litigation.
[88] Ibid.
[89] Cave (n 4), 157.
[90] Hereinafter 'the Ombudsman'.

Health Committee[91] for the future shape of the complaints process and the redress for iatrogenic harm it may offer complainants.

Chapter 8 NHS Redress Act 2006 – A Lost Opportunity

The NHS Redress Act 2006[92] is the only statute entirely concerned with clinical negligence,[93] and is important because it potentially affects NHS hospital patients, with the intention to extend its operation to primary care. The underlying policy of the NHSRA 2006 was to provide a genuine alternative to litigation for low-value claims.[94] The Act, wholly concerned with the process of compensation, proposes a redress package where there has been clinical negligence in hospital. The redress scheme would be run by the NHS Litigation Authority (hereinafter 'NHSLA').[95] In addition, the Act was to provide a more integrated system of complaints and compensation.[96] *I will argue that in not providing this integrated system, the major lost opportunity occurred.*

Indeed, the lost opportunity regarding the Act is twofold: the *failure to draft regulations*, leaving in doubt whether the NHS Redress Scheme would be developed in England at all; *and in the actual proposed provisions* which 'failed by a large margin to live up to the aspirations for a radically different way of compensating patients'.[97] As regards the failure to enact the scheme, the previous Government[98] did not capitalise on the unique consensus in all of the Parliamentary debates that an alternative to litigation had to be found. The provisions of the Act did at least offer some alternative, though modest, improvement.[99] Most significantly, the Act would have offered a preferable procedural route when compared with litigation and could potentially combine compensation with apologies, explanations and system change, but the Act has not as

[91] 'Complaints and Litigation' (n 16).
[92] Hereinafter NHSRA 2006.
[93] A Barton, 'Compensation Schemes', ch 4 in Powers, Harris and Barton (n 11), Redress Act section at 4.2-4.19.
[94] AM Farrell and S Devaney, 'Making Amends or Making Things Worse? Clinical Negligence Reform and Patient Redress in England' (2007) 27 *Legal Studies* 4, 630-648. It is in the low cost claims that the costs are most disproportionate to the damages awarded.
[95] Barton (n 93).
[96]See A Simanowitz and S Burn, 'Clinical Disputes Forum: Litigation and Complaints – an Integrated System?' A Consultation Paper (London, Clinical Disputes Forum, September 2001). *Consultation paper – September 2001.*
[97] P Walsh 'Editorial' (2008) 14 *The AvMA Medical and Legal Journal* 4.
[98] Labour Government 1997-2010.
[99] Walsh (n 97).

yet been implemented.[100] I offer, for comparison, the new Welsh alternative compensation systems for low-value clinical negligence claims, namely the Welsh Redress Scheme and the Welsh Speedy Resolution Scheme, which will both co-exist with the litigation route for the foreseeable future.[101]

Chapter 9 Effective Redress and the Role of Apologies

This concluding chapter is concerned with what an effective redress system would contain. I have already addressed this issue when considering the complaints procedure[102] and in this chapter I look more broadly at the problem of redress for the more intangible aspects, focusing on redress for non-pecuniary loss. The chapter starts, in Section II, with a review of the central problems in the current system(s). I then turn in Section III to consider what an effective redress system would look like. In this regard, because knowledge and acknowledgement of the adverse event is crucial both to litigation and complaints, I have chosen to focus on the role of apologies in facilitating effective redress and have considered the purported effect or otherwise of apologies on litigation. I conclude that without a system for *full apologies*, as defined in the chapter, there cannot be effective redress. However, to achieve the aims of corrective justice, redress would have to include forms of reparation and compensation. The nearest model for effective redress for iatrogenic harm in the UK is in its embryonic form in Wales.[103] Looking to the future, it will be instructive to monitor how well the redress scheme in Wales and the possible no-fault system in Scotland serve iatrogenically harmed patients.

IV. CONCLUSION

An adverse event is a tragedy for the patient, the latter's family and the physician. Many doctors consider their vocation the essence of their being and are understandably mortified and anxious when their judgement or practice is questioned. In clinical negligence cases, the damage involves intangibles as well as pecuniary loss, and thus it

[100] Brazier and Cave (n 35), 270.
[101] Welsh Government, *Putting Things Right – A better way of dealing with concerns about health services* Consultation Report (2 August 2010), 12.
[102] Chapter 7 History of NHS Complaints Processes – 'A Curate's Egg?' Introduction section and Ann Abraham, The Health Service Ombudsman for England, 'Making Things Better? A Report on Reform of the NHS Complaints Procedure in England' HC 413 (London, The Stationery Office, 9 March 2005), ch 3, 'Key Elements of a New System'.
[103] Chapter 8 'The Redress Act 2006 – A Lost Opportunity'.

is usually impossible to restore the victim to his former whole self. However, in a just society, the tortfeasor bears the onus of offering compensation. Because 'the shopping list of the clinical negligence claimant is varied',[104] this thesis has considered the different types of redress presently and potentially available. The current situation offers inadequate redress, for there are difficulties with eligibility for both the litigation and the NHS schemes, difficulties with funding litigation, problems with obtaining information about adverse events and of obtaining apologies, if appropriate. I suggest one new initiative in order to extend the range of redress, namely, full apologies. Because the NHS is a communal and valued enterprise, deliberation regarding the conflicting demands on its budget is difficult. Nevertheless, justice in the form of redress for iatrogenic harm must be an integral part of a national health service.

[104] Balen (n 77), vi.

CHAPTER 1

CORRECTIVE JUSTICE AND ENTITLEMENT TO REDRESS WITHIN THE NHS

> It is possible to view the case simply from the perspective of corrective justice. It requires someone who has harmed another without justification to indemnify the other…But one may also approach the case from the vantage point of distributive justice. It requires a focus on the just distribution of burdens and losses among members of a society.[1]

[1] *McFarlane v Tayside Health Board* [2000] 2 AC 59, 83, *per* Lord Steyn.

I. INTRODUCTION

With the National Health Service in England fast approaching its sixty-fifth year of existence, now is an opportune time to consider the vexed question of meaningful redress for patients injured in the course of their medical treatment. The founding of the National Health Service was an historic post-war enterprise. Understandably, in the euphoria of its inception, attention was rightly focused on treatment delivery rather than on adverse events. Little thought was given, when the NHS began (and doctors became employees of the new State-run service), as to who would be sued in case of medical negligence.[2] However, risk is an inherent part of treatment and things can and do go wrong.

In this, my opening chapter, I will discuss the legal and philosophical basis for patients' entitlement to redress within the NHS. This is addressed in the context of the changing perception of patients initially as passive recipients of care and latterly as active citizens with rights. Liability for iatrogenic harm is derived from the concept of fault.[3] After consideration of the importance of the idea of fault, I will discuss the philosophical basis of the imperative to make good by reference to theories of corrective and distributive justice, using the case of *MacFarlane v Tayside*[4] as an example. My argument will be that while corrective justice underpins the necessity of full compensation for pecuniary loss, in the case of damages for non-pecuniary loss, other factors come into play. These include the responsibility of the NHS to the wider community based on notions of distributive justice and the uncommodifiablity of these losses. The discussion is limited to the special circumstances inherent in a national health service with a mandate to treat the citizenry within the limits of a constrained budget. The chapter concludes with thoughts about alternative redress for non-pecuniary loss.

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[2] Chief Medical Officer, *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (London, Department of Health, 2003) [CMO, Making Amends] 58.
[3] P Cane, *Atiyah's Accidents, Compensation and the Law* 7th edn (Cambridge, Cambridge University Press, 2006) 421.
[4] [2002] 2 AC 59.

A. From Recipients to Citizens

Current developments in healthcare provision prompt a number of questions about the nature of medical relationships and the legal principles which govern them. Until recently, there was relatively little opposition to the traditional medical view of patients as passive recipients of medical care. It was widely accepted that doctors might decide unilaterally what treatment should be provided and presume how much a patient wanted or needed to know. Such paternalistic attitudes and practices were entrenched features of medicine, conveniently justified as serving the patient's welfare.[5] However, with the publication of Ian Kennedy's persuasive Reith Lectures attacking the dominance and paternalism of the medical profession, the climate began to change.[6] The language of the argument changed to one based on the concept of patients' rights. The patient's voice having been insufficiently heard, the assertion of 'patients' rights' is now presented as a natural antithesis to medical paternalism, proclaiming the moral agency of the individual and the intrinsic value of respect for the patient as a person.[7] As regards the law, the number of actions for malpractice against doctors, once virtually unknown in England, has grown substantially.[8] Patients find the English legal system obstructive and cripplingly expensive. Nor are their grievances limited to lack of provision for compensation for medical mishap. Increasingly, patients demand a greater say in their treatment. The extent to which it is right for patients to have their own say becomes ultimately a question for the law.[9] At the core of this thesis, then, is the need of

[5] J Miola, *Medical Ethics and Medical Law* (Oxford, Hart Publishing, 2007) 33.
[6] I Kennedy, *The Unmasking of Medicine* (London, George Allen & Unwin, 1981).
[7] See H Teff, *Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship* (Oxford, Clarendon Press, 1994) Introduction for examples and further discussion. Also note the use of rights language in *Chester v Afshar* [2005] 1 AC 134 (HL) where the majority (Lord Steyn, Lord Hope and Lord Walker) were at pains to emphasise considerations of policy and corrective justice, rather than 'traditionalist causation' techniques. The policy reasons advocated by the majority in this case can be summarised as the right of the autonomy and dignity of the claimant, the duty to warn has at its heart the right of the patient to make an informed choice as to whether and if so when and by whom to be operated on. Lord Hope emphasised that 'the function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done, the duty is a hollow one, stripped of all practical force and devoid of all content.'
[8] V Harpwood, *Medicine, Malpractice and Misapprehensions* (Abingdon, Routledge-Cavendish, 2007) 2 states that 'The volume of clinical negligence cases has increased dramatically – by as much as 1,200 per cent – over the past thirty years.' Figures from the NHSLA in 2009/10, indicates that 6,652 claims of clinical negligence and 4,074 claims of non-clinical negligence against NHS bodies were received by the Authority, up from 6,088 claims in 2008/09. £787 million was paid in connection with clinical negligence claims during 2009/10, up from £769 million in 2008/09, see http://www.nhsla.com.
[9] M Brazier and E Cave, 'Why We Wrote…Medicine, Patients and the Law' (2008) 3 *Clinical Ethics* 205–208.

autonomous patients[10] to be cared for and their right to redress when things go wrong. A sub-theme concerns the needs of the medical practitioner for sufficient autonomy and legal protection to practise his profession,[11] mindful of the best interests of the particular patient. The issue of redress is contingent upon access to justice and to legal representation for all parties. All this occurs within the constraints of a hard-pressed National Health Service still fighting for the ethos of medical help free at the point of delivery.

One of the most powerful criticisms of the tort system is that it is inefficient in delivering compensation to an injured person. From the patient's point of view, the difficulties of establishing causation and negligence make it hard to make a successful claim. Even if a causally significant breach of the standard of care is established, the slow and expensive nature of the legal process absorbs a significant portion of the total cost of the system, resulting in the injured party's receiving in damages only a small part of the overall cost.[12]

A similar criticism may be made with regard to the overall social efficiency of the tort system. Compensation for medical injury may come from a variety of sources. In a system of state-financed medical care, it is ultimately the state that will pay for such compensation.[13] As will be discussed in the section on medical negligence litigation,[14] for the majority of claimants, stressful and expensive litigation will end in disappointment. Research appears to indicate that even where claimants are awarded damages, many remain dissatisfied because they have not been given an explanation, an apology, or reassurance that the same thing will not happen again.[15] Therefore, in addressing the issue of entitlement to redress, the latter is not confined to damages.

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[10] Their autonomy and rights strengthened by the Human Rights Act 1998.
[11] See Part III Redress Within the NHS, below.
[12] A Merry and A McCall Smith, *Error, Medicine and the Law* (Cambridge, Cambridge University Press, 2001) 212. Until the introduction of NHS indemnity in January 1990, the cost of any compensation award against a hospital doctor was shared between the NHS and the doctor's medical defence union. Then and until 1995, when the clinical negligence scheme for trusts was introduced, hospitals effectively insured themselves against claims. Now, all hospital negligence claims are paid for by the NHS, thereby reducing the amount available for all other health expenditure.
[13] The NHS Litigation Authority handles negligence claims and works to improve risk management practices in the NHS. For statistics on number of claims handled in recent years see n 8.
[14] Part II Medical Negligence Litigation, below.
[15] L Mulcahy, *Disputing Doctors: The Socio-Legal Dynamics of Complaints about Medical Care* (Maidenhead, Open University Press, 2003) 96 and E Jackson, *Medical Law* 2nd edn (Oxford, Oxford University Press, 2010) 149. See also below ch 2 'What Patients Seek from Redress' and Part III Redress Within the NHS.

II. ENTITLEMENT TO REDRESS: COMPETING THEORIES OF JUSTICE

Entitlement to redress for iatrogenic harm sustained within the NHS rests upon legal and moral precepts. Legal entitlement may be based on actions for breach of contract, possible if a patient has paid for his medical treatment,[16] but more usually tort actions based upon an actionable claim for personal injury, which the Limitation Act 1980[17] defines as: '...any disease and any impairment of a person's physical or mental condition... .'

Briefly, in order to succeed in an action for negligence, the claimant must establish:

a. that the healthcare professional owed the complainant a duty of care – ie a *legal* duty, which is a matter for the courts to decide;
b. that there was a breach of duty to the extent that the standard of care provided fell below the standard required by the law – thus, although by definition this is a legal concern, the courts must, and do, defer to *professional* standards;
c. that because of that breach, the patient suffered a legally recognisable harm – the problem of causation.[18] In the context of clinical negligence cases, assessment of the extent of the 'impairment of condition' is often more complex than in other types of personal injury because of the claimant's pre-existing condition. In many cases, the claimant would have had a level of ongoing injury but for the negligence. This impacts significantly on the value of these claims and makes the process of valuation generally more difficult.[19]

Legal entitlement to redress is itself informed by the idea of corrective justice which requires that those who have, without justification, harmed others by their conduct put the matter right.[20] Clinical negligence claims usually involve one party, the patient or his family, seeking damages from another party, the doctor and/or his employing health facility, on the basis that the latter is responsible for the former's injuries. Responsibility

[16] No contract exists between doctor and patient within the NHS: *Pfizer Corporation v Ministry of Health* [1965] AC 512. However, see L Hoyano, 'Misconceptions and Wrongful Conceptions' (2002) 65 *Modern Law Review* 883, 904 'The legal status of claims of patients who can afford private healthcare and so sue in contract remains unclear'.
[17] Limitation Act 1980, s 38(1).
[18] See Part II Medical Negligence Litigation below.
[19] P Balen, *Clinical Negligence* (Bristol, Jordan Publishing Limited, 2008) 471.
[20] A Honoré, 'The Morality of Tort Law –Questions and Answers' in D Owen *Philosophical Foundations of Tort Law* (Oxford, Oxford University Press, 1995) 73 at 79.

for personal injuries in tort law rests on the notion of fault.[21] In this chapter, after a brief discussion of the role of fault, I will introduce relevant aspects of corrective and distributive or communitarian[22] justice theories. I will then argue that patients who are harmed in the course of their treatment should be compensated in full for their pecuniary losses because corrective justice demands this. However, I will also argue that within the special context of a welfare national health service, their entitlement to redress for loss is finite. Therefore, while I would look to the principles of corrective justice when expecting the harm-doer to be responsible for the repair of the harmed, I would look to the principles of distributive justice when considering financial redress for non-pecuniary losses. Non-pecuniary loss is usually defined as a claim for 'general damages' which incorporates losses where valuation is imprecise and subjective, namely, pain, suffering and loss of amenity and, *inter alia*, loss of enjoyment and leisure time, loss of congenial employment, and marital breakdown. As Emily Jackson has noted, almost every medical dilemma could be framed in terms of a tension between two or more basic principles.[23] I will argue that patients should not receive damages for these non-pecuniary losses, not only for practical reasons such as NHS budgetary restraints, but because the uncommodifiability of these losses indicates the futility of so doing.[24] I will be considering alternative responses for redressing these losses in the final chapters of the thesis.

After discussion of the theories of justice underpinning the need or otherwise for redress for iatrogenic harm, I will consider the seminal case of *McFarlane v Tayside Health Board.*[25] In that case, although negligence was admitted as regards wrongful conception and recovery for the mother's claim was allowed*,* the cost of bringing up the healthy child was disallowed on public policy grounds which included, *inter alia,* references to the potential burden on NHS resources that could be a consequence of such claims. In the last section of this chapter, I will introduce the succeeding parts of the thesis regarding medical negligence litigation and redress within the NHS.

[21] Cane, n 3, 421.
[22] JK Mason and GT Laurie, *Law and Medical Ethics* 7th edn (Oxford, Oxford University Press, 2006) 6.
[23] Jackson, n 15, 17.
[24] See Part II Chapter 6 Damages below for fuller discussion of non-pecuniary loss.
[25] *McFarlane v Tayside Health Board* [2000] 2 AC 59.

A. The Role of Fault

Fault is the basic cement of the clinical negligence action. Fault permeates the structure of tort law doctrine, providing both definition and justification for the great majority of rules governing private responsibility for causing harm. What fault is, therefore, and how in moral theory it may claim to dominate this area of law, are questions of fundamental importance to an understanding of tort law. 'Fault' is often addressed in terms of 'blame' or 'wrong': faulty conduct is 'blameworthy' or 'wrongful conduct' and the challenge is to determine, in actions for iatrogenic harm, whether a particular person's harmful behaviour was blameworthy or wrongful, ie whether the person was at fault.[26]

The question of when one can hold an actor responsible for his actions permeates the philosophical literature.[27] 'What is required in the medical context is a clear-eyed, properly informed examination of the grounds for blame, and a firm fixing of these grounds to criteria which are both morally defensible and pragmatically productive.'[28] Alan Merry and Alexander McCall Smith have argued that many errors are not the product of failures or shortcomings of a culpable nature. Rather, certain types of errors are inextricably linked to those human strengths (such as distractibility and creativity) which differentiate us from machines and which have contributed to our success as a species.[29] Their analysis reveals that to attribute blame for an error is to misunderstand the very nature of what is happening when an error is made. Slips or lapses, for example, will be made by the most conscientious of people and do not, of themselves, demonstrate any culpable failing sufficient to justify the attribution of blame. The same is generally true of rule-based and deliberate errors. Errors are not the product of choice.

I would, however, ask 'Why should such errors not be culpable?' If one believes that moral culpability depends on the making of a free choice, then any human action which is not the result of such a choice cannot involve blame. This is not a novel position in moral philosophy; indeed, the place occupied by freedom in theories of moral responsibility finds its roots in Aristotle and has been central to theories of

[26] See Part II Medical Negligence Litigation below. Also DG Owen 'Philosophical Foundations of Fault in Tort Law' in D Owen (ed), *Philosophical Foundations of Tort Law*, n 20, 201.
[27] Ibid, 202–206. A full discussion is outwith the remit of this chapter.
[28] Merry and McCall Smith n 12, their final chapter 'Conclusions'.
[29] Ibid.

responsibility since then.[30] It is on the basis of the absence of a free choice of course of action that those who act under coercion are exculpated; similarly, those who act in ignorance are not usually held to be culpable, on the grounds that their actions do not represent an informed choice of the resulting harm.[31] In practice, however, the making of an error will often be construed as negligence. In the medical context, errors can have grave consequences:

> The power inevitably held by the doctor in our society is matched by the human cost of any error he may make. When an overstretched accountant makes a mistake, she will probably get a chance to put it right the next day. The junior doctor who has been working continuously for over thirty-six hours may get no second chance. Nor is there a second chance for the patient. The accountant or the solicitor may cause her client to lose money or property. Monetary compensation paid for out of the professional's insurance cover will go some way to placate the client. For the patient whose doctor's mistake resulted in disability or death, money is poor compensation. Finding out why things went wrong may be more important to the patient and the family. The difficulties in finding out 'why' may explain the bitterness that attends many claims against the medical profession.[32]

Nevertheless, Merry and McCall Smith have argued that, in the case of errors, the only failure is a failure defined in terms of the normative standard of what should have been done. There is a tendency to confuse the *reasonable person* with the *error-free person.* In other words, the test has shifted from what *could reasonably* have been expected to what *ought* to have been done. Even though the courts have repeatedly said that the reasonable person test is anchored in realistic expectations of people, the reasonable person test has progressively failed to take account of the inherent human limitations of actual reasonable people.[33]

My contention is that the inescapable tension in the law of torts between the principle of compensation for loss caused by another, on the one hand, and the principle that only those who deserve to pay compensation should be required to do so, on the other hand, has not been resolved satisfactorily. It remains the case that negligence liability in the common law system is founded on fault and this notion of fault is not one which is

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[30] R Wright, 'Right, Justice and Tort Law' in D Owen, *Philosophical Foundations of Tort Law*, n 20, 159.
[31] Ibid, 169.
[32] Although the current M Brazier, *Medicine, Patients and the Law*, 5th edn (Harmondsworth, Penguin, 2011) expresses the same idea, the actual quotation is from the third edition of that work, page 6.
[33]See Merry and McCall Smith, n 12, their final chapter 'Conclusions' and their Chapter 5 'Negligence, Recklessness and Blame' for alternative formulations of classifications of blame. (Emphasis added by Merry and McCall Smith).

entirely amoral in nature. The transfer of loss from the person who has suffered it to the person who has caused it depends on the latter having fallen below a standard which it is thought he should have reasonably met.[34] This is unobjectionable, even if it means that those who were not *subjectively* negligent will be held liable. Merry and McCall Smith make the point that the reasonable person's expected level of performance must take into account the fact that the reasonable person is a human being with the normal limitations of even the most conscientious human being. If the standard ceases to represent the level that can in reality be expected of the reasonable person, then it could be argued that the moral underpinning of negligence liability has been lost. If the standard becomes too high, it will be a disincentive for people to engage in high-risk activities such as medicine. The psychological cost of civil litigation on doctors and patients is high and stressful for all, even if it is technically not about moral opprobrium. Linda Mulcahy makes a plea for the interests of both the patient for redress and the doctor, who can have a long-lasting emotional reaction to a complaint, to be taken into account.[35]

I think, given what is at stake, that it is illusory to imagine a pain-free process of resolution of claims for compensation for iatrogenic harm. Nevertheless, in my final chapter, I will be considering what processes, in addition to damages, might make for more effective redress; apologies being a case in point.[36] Of course, how people view compensation or redress depends critically on their conception of justice. It is to this that I now turn.

B. Concepts of Justice

When injured people clamour for recourse against their injurers, their concern is not just with compensation, but with justice. If many victims of wrongs do not get redress, the problem is not just one of undercompensation, but of injustice. If compensation is extracted from someone who is not responsible for an injury, the problem is again one of injustice, not just expense. When money, power and the personal sympathies of

[34] See Part II Medical Negligence Litigation below.
[35] L Mulcahy, n 15, 147.
[36] Chapter 9 Effective Redress below.

judges speak too loudly, it is the voice of justice that they silence. But the disappointments reveal the force of the animating idea of justice between persons.[37]

A good starting point to the elucidation of the tensions between applying ideas of corrective or distributive justice in matters of redress for personal injury within a national health service is to be found in academic writing.[38] One might ask the following questions: 'What is the rationale for an individual's "right" to recover for his losses? What are the criteria for justly singling out some people and making them, and not their neighbours, bear the costs of accidents?' In short, what underpins the moral imperative to offer redress to victims of iatrogenic harm? John Harris has argued that there is a fundamental unfairness in paying awards to the victims of medical injury even when fault has been established, given that there are other pressing demands being made on the same funds. Harris suggests that, although victims of negligence may have a claim, this claim should not have priority over the needs of those whose claim is for a non-injury related medical condition.[39] He states his case very effectively:

> When judgment is delivered by the courts, payment becomes due immediately and hospitals have to pay the compensation awarded against them. Thus, successful litigants get immediate and absolute priority in the deployment of public resources allocated for health. This guarantee of access to health resources for successful litigants highlights an important ambiguity when allocation decisions are based on scarcity...[40]

Harris is also concerned that judges are not made aware of the effect on healthcare resources when ordering compensation payments in medical litigation.[41]

While Harris concentrates on the relationship between the victims of clinical negligence and the general patient pool, my emphasis is on the nexus between the victims and the defendant health facility. I believe that a mature universal health service must be accountable and incorporate a comprehensive compensation scheme available when there has been iatrogenic harm. I am mindful of the calls on NHS budgets and the

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[37] A Ripstein, 'Some Recent Obituaries of Tort Law' (1998) 48 *University of Toronto Law Journal* 4, 561.
[38] G Fletcher, 'Fairness and Utility in Tort Theory' (1972) 85 *Harvard Law Review* 535, 538.
[39] J Harris, 'The Injustice of Compensation for Victims of Medical Accidents' (1997) 314 *British Medical Journal* 1821.
[40] Ibid.
[41] Whether this is so is discussed below. Both Harris and Merry and McCall Smith discuss alternative compensation systems.

principles of distributive justice. However, I am arguing for the withholding of payment for non-pecuniary loss not solely on public policy grounds,[42] but rather on the grounds of the futility of money for these losses.

Additionally, it is noteworthy that there is a perceived inequality between people injured by accident who can make a claim for damages and those people with serious illness and disability who will not receive damages at all. Only those who can establish iatrogenic harm will receive generous financial assistance with the costs of their care. Whether or not a social security system or a welfare state which allocates resources according to need might be fairer than the tort of negligence is beyond the remit of this thesis. For present purposes the discussion will concentrate on the extant tort system.[43]

1. Claimants and Defendants: Their Relationship

There are several ways of defining the relationship between claimants and defendants. How one defines this relationship is key in determining one's conception of justice between the parties. On one view there is the 'paradigm of reciprocity';[44] on another the 'indispensable nexus between the parties'[45] and finally, there is the 'language of responsibility'.[46] These will be discussed in turn.

In the first instance there are two distinct issues: whether the victim is entitled to receive and whether the defendant ought to pay. The relationship between victim and defendant is seen as an example of the 'paradigm of reciprocity'. This paradigm of reciprocity looks only to the activity of the victim and the risk-creator. The distinct question under this paradigm is whether the risk was non-reciprocal and unexcused, namely: was the risk unreasonable? The reasonableness (liability) of the risk thus determines both whether the victim is entitled to compensation and whether the defendant should be held liable. It becomes a question of balancing costs and benefits.[47] The function of George Fletcher's paradigm of reciprocity and liability is to distinguish between those risks

[42] 'Relying on the principles of distributive justice I am persuaded that our tort law does not permit parents of a healthy unwanted child to claim the costs of bringing up the child from a health authority or a doctor…'. See Lord Steyn in *McFarlane v Tayside Health Board* n 25.
[43] For further discussion see ch 18 in Cane, n 3.
[44] Fletcher, n 38 at 538.
[45] E Weinrib, 'Towards a Moral Theory of Negligence Law' (1983) 2 *Law and Philosophy* 37, 38.
[46] A Honoré, 'Responsibility and Luck', (1988) 104 *Law Quarterly Review* 530–553.
[47] Refer to discussion below regarding the effect of risk liability on doctors.

which represent a violation of individual interests and those which are the background risks that must be borne as part of group living.[48]

An alternative view, however, points to the 'indispensable nexus between the parties'.[49] It is asserted that tort law embodies corrective, rather than distributive justice, and the requirement of factual causation establishes an indispensable link between the victim and the tortfeasor by relating their rights to a transaction in which one has directly impinged upon the other. Ernest Weinrib asserts that tort law, while not concerned with abstract ideas of wrongful conduct, is concerned with the right of recovery against a specific tortfeasor, who must respond to the harmed individual for the damage which he has caused.

A more elegant approach speaks in the language of 'responsibility'[50]. Assuming that the actor (defendant) possesses a general capacity for decision and action, he is responsible for what he does and its outcome is 'inseparable from his status as a person'. Tony Honoré considers that the main role of legal liability is to reinforce our basic outcome-responsibility with formal sanctions, such as compensation or punishment.[51] The idea of 'responsibility' covers a wide spectrum. It does not necessarily import legal liability or moral blame, although it is a condition of both. Honoré points out that human responsibility may relate to (a) our own conduct, (b) the responsibility that we choose to take on for other people, things and events; and (c) the responsibility that society thrusts upon us. Honoré's three aspects of responsibility remind us that liability may stem from omissions as well as acts, including the acts or omissions of a third party. They also show the fallacy of limiting duty of care to 'assumption' of an obligation to control a person or a situation.[52]

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[48] Fletcher, n 38 at 538. Fletcher then describes non-reciprocal risk and issues of fault at 539.
[49] E Weinrib, n 45.
[50] A Honoré, n 46.
[51] Ibid, 531. Honoré then discusses the requirements in a negligence action, namely fault as a failure to reach the objective standard of competence and the assumption that the actor 'could have done otherwise' which is an implicit factor.
[52] See Honoré, *Responsibility and Fault* (Oxford, Hart Publishing, 1999) 125 and K Mason 'Fault, Causation and Responsibility: Is Tort Law Just An Instrument of Corrective Justice?' (2000) 19 *Australian Bar Review* 201. Also refer to Part III Redress Within the NHS below for discussion of the principle of medical responsibility for an act itself and/or responsibility only for the consequences and outcome of the act.

All three definitions can be applied to clinical negligence situations: the 'paradigm of reciprocity'[53] related to the standard of care; the 'indispensable nexus between the parties'[54] describing the doctor-patient relationship; while the 'language of responsibility'[55] places clinical negligence in context. I now turn to the framework within which one considers the appropriate balance of responsibilities when treatment goes amiss.

2. Corrective Justice

Despite semantic differences,[56] all of these definitions of the relationship between the injured party and the tortfeasor conform to Weinrib's account of the Aristotelian definition of corrective justice:

> Corrective justice is the idea that liability rectifies the injustice inflicted by one person on another. This idea received its classic formulation in Aristotle's treatment of justice in *Nicomachean Ethics*, Book V.[57]

Weinrib asserts[58] that Aristotle presents corrective and distributive justice as two contrasting forms of justice. Corrective justice, which deals with voluntary and involuntary transactions (contracts and torts) focuses on whether one party has committed and the other has suffered a transactional injustice. Distributive justice, discussed below, deals with the distribution of whatever is divisible (honours and goods) among the participants in a political community. For Aristotle, justice in both these forms relates one person to another according to a conception of equality or fairness. Injustice arises in the absence of equality, when one person has too much or too little relative to another.

The two forms of justice differ, however, in the way they construe equality. Distributive justice divides a benefit or burden in accordance with some criterion that compares the relative merits of the participants. Distributive justice, therefore, embodies a

[53] Fletcher, n 38 at 538.
[54] Weinrib, n 45.
[55] Honoré, n 46.
[56] See also Peter Cane's theory of tort law as correlativity: 'Civil law organizes relationships between individuals on a one-to-one basis' quoted in A Ripstein n 37, 561.
[57] E Weinrib, 'Corrective Justice in a Nutshell' (2002) 52 *University of Toronto Law Journal* 349–346; Aristotle, *Nicomachean Ethics,* V, 2–5, 1130a14–1133b28.
[58] Ibid.

proportional equality, in which all participants in the distribution receive their shares according to their respective merits under the criterion in question.[59]

Corrective justice, in contrast, features the maintenance and restoration of the notional equality with which the parties enter the transaction. This equality consists in persons having what lawfully belongs to them. Injustice occurs when, relative to this baseline, one party realises a gain and the other a corresponding loss. The law corrects this injustice when it re-establishes the initial equality by depriving one party of the gain and restoring it to the other party. Of course, in the field of clinical negligence one is not referring to gains and losses, but rather to 'rights and correlative duties'.[60]

One answer to the question posed above, namely, 'Why is this claimant entitled to recover from this particular defendant?' is that, in sophisticated systems of private law, the overarching justificatory categories expressive of correlativity are those of the claimant's right and the defendant's corresponding duty not to interfere with that right. Right and duty are correlated when the claimant's right is the basis of the defendant's duty and, conversely, when the scope of that duty includes avoiding the kind of right-infringement that the plaintiff suffered. Under those circumstances the reasons that justify the protection of the claimant's rights are the same reasons that justify the existence of the defendant's duty[61].

Negligence law provides a paradigmatic example of the operation of such correlativity in the common law. For the defendant to be held liable, it is not sufficient that the defendant's negligent act resulted in harm to the claimant. The harm has to be to an interest that has the status of a right and the defendant's action has to be wrongful with respect to that right. As Justice Cardozo stated in *Palsgraf v Long Island Railroad Co.*[62] a leading judgment explaining the notion of tortious wrong, 'What the plaintiff must show is a 'wrong' to herself; ie, a violation of her right and not merely a wrong to someone else, nor conduct 'wrongful' because unsocial but not 'a wrong' to anyone.' Under the condition stated by Cardozo J, freedom from the injury of which the claimant is complaining is both the content of the claimant's right and the object of the

[59] For relevance to the NHS and compensation see discussion of the work of John Harris below.
[60] Weinrib, n 57. Most tort cases of accidental harm feature a loss by the claimant from which the defendant realises no corresponding gain.
[61] Ibid.
[62] *Palsgraf v Long Island Railroad Co* [1928] 162 N.E. 99 at 100 (NYCA).

defendant's duty. In claims for personal injury the specific rights and interests of the claimant are those pertaining to the rights to the integrity of one's body. The existence of these rights and interests gives rise to correlative duties of non-interference.[63]

Correlativity then obtains because the parties are the doer and the sufferer of the same injustice, and the reason for the claimant's entitlement to win the negligence action would be the same reason for the defendant's liability to lose it. In the context of corrective justice, therefore, liability consists in a legal relationship between the two parties, each of whose position is intelligible only in the light of the other. In holding the defendant liable to the claimant, the court is making not two separate judgments (one that awards something to the claimant and the other that coincidentally takes the same from the defendant), but a single judgment that embraces both parties in their interrelationship. Corrective justice, then, is the theoretical construct that highlights the role of correlativity as the organising idea implicit in the relationship between the claimant and the defendant.[64]

It is submitted that corrective justice as a basis for clinical negligence actions can be seen as psychologically satisfying[65] and biblically justified.[66] This is particularly so, if one considers that liability is predicated upon fault.[67] Justifications of tort-based compensation may also be made on both theoretical and pragmatic grounds. The theoretical justification of the tort system is that considerations of justice require fault-based compensation to be sought from the person who is causally responsible for a loss or injury. Looked at in this way, the denial to an injured party of the right to bring a legal action amounts to the condoning of a wrong.[68] Particularly in clinical negligence cases, the process of suing a defendant is more than an attempt to recover a loss or to seek monetary compensation for pain and suffering: it may well represent the desire to

[63] Weinrib, n 57, who links these ideas with Kantian principles.
[64] Ibid.
[65] Making psychological sense, fitting in with one's intuitive world view and therefore 'ego syntonic'.
[66] 'An eye for an eye' Exodus xxxi, 24.
[67] See Owen n 26, 201.
[68] The denial of a chance to sue refers to some no-fault systems. This could be challenged on constitutional or human rights grounds, eg a challenge based on The Human Rights Act 1998 Article 6 'right to a fair trial'.

seek an explanation of what happened[69] and, indeed, may also be an attempt to secure some form of retribution.[70]

However, Merry and McCall Smith have argued that in the context of medical misadventures, singling out an individual may sometimes obscure the real systemic nature of the responsibility for the incident.[71] The counter-productiveness of the role of 'blaming behaviour' in the context of non-deliberate actions is also addressed by the authors. Nevertheless, I believe that a merit of the current clinical negligence action is that it allows a defendant to mount a vigorous defence with a view to establishing that an injury is not due to incompetence (falling below the requisite standard) but instead reflects no more than an inevitable concomitant of an inherently risky procedure.

There are, however, caveats to accepting corrective justice as the only philosophical basis for tort actions in cases of alleged clinical negligence within the context of a welfare national health service, in particular, the vexed question of the cost of both litigation and damages. This latter issue is the driving force behind support for distributive justice as the model for damages or compensation:

> If damages become payable, then that means that there is a correspondingly reduced amount available for the maintenance of wards and equipment, the purchase of drugs or the provision of treatment. A medium sized award, therefore, may be crudely translated into ten fewer hip replacements.[72]

3. Distributive Justice

While it is clear that corrective justice links the claimant's claim to the defendant's wrong and one person's right is always a function of another person's duty,[73] the definition of distributive justice is more elusive. The two forms of justice both concern the allocation of resources; but they differ in that under distributive justice, individuals'

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[69] This is precisely what independent reviews of medical care by the Healthcare Commission were meant to address.

[70] FA Sloan, K Whetten-Goldstein, SS Entman, ED Kulas and EM Stout, 'The Road From Medical Injury to Claims Resolution; How No-Fault and Tort Differ' (1997) 60 *Law and Contemporary Problems* 35–70. Also ch 8 'Responding to the Needs of the Injured' in Merry and McCall Smith, n 12.

[71] Final chapter 'Conclusions' in Merry and McCall Smith, ibid, 242–3. Also see J Harrington, 'Elective Affinities: the Art of Medicine and the Common Law' 55 *Northern Ireland Legal Quarterly* 259.

[72] Merry and McCall Smith, n 12, 212.

[73] P Cane, 'Corrective Justice and Correlativity in Private Law' (1996) 16 *Oxford Journal of Legal Studies* 3, 471.

entitlements are not correlative to other individuals' obligations. Loss spreading may be seen as a principle of distribution, not of correction.[74] Peter Cane, discussing Weinrib,[75] continues: 'a judgment that a situation is distributively just cannot be made without reference to some *extrinsic* principle of distribution; and such a principle is *political*'.[76] The notion of distributive justice has no principle of just distribution built into it, in contrast to the notion of corrective justice[77] which encompasses what is just and unjust without reference to any external criterion.

In discussing *Bolton v Stone*[78] Weinrib[79] makes the point that in this case, the choice between the two outcomes was ultimately a question of distributive justice: should the cricket Club have an entitlement to injure or should the passer-by have an entitlement to be free of injury? The likeness with clinical negligence cases takes us back to the point made by Harris that victims of medical negligence should compete for scarce NHS funds according to the same rationing that exists throughout the NHS, rather than, as happens now, being given absolute priority. My position is less harsh on victims of iatrogenic harm. I will argue that because non-pecuniary losses are intangible and ill-fitted to monetary redress *and* because the context is one of budgetary constraint within a communal NHS, damages should not be paid for them. It is not to say that there is no entitlement for non-pecuniary loss, rather that an alternative to financial redress is desired by victims of iatrogenic harm and what form this might take is addressed in the final chapter.[80]

Before turning to the case law and judicial discussion of corrective and distributive justice, I turn to the idea of communitarianism, an extension of distributive justice, which helps shed light on decisions of entitlement to redress in the medical setting.[81]

In contrast to the ideal of personal autonomy as the cornerstone of medical ethics and medical law, the communitarian ethos visualises the community as the integral unit in

[74] Ibid, 472.
[75] Ibid, 475 (Emphasis added by Cane). See also E Weinrib, *The Idea of Private Law* (Cambridge, Mass, Harvard University Press, 1995).
[76] See discussion of *McFarlane v Tayside Health Board* [2000] 2AC 59 below. Also Lord Steyn's appeal to notional commuters in *McFarlane* at 82.
[77] Which Weinrib bases on the Kantian principle of right.
[78] [1951] AC 850.
[79] Ibid, 479.
[80] Part III Chapter 9 'Effective Redress' below.
[81] Mason and Laurie, n 22, 6–8.

which autonomy is expressed.[82] Communitarianism is seen as a state that is modified by a sharing of values with those of the group in which the individual operates. Put in practical terms, the rightness or wrongness of an action is to be judged by the goodness or badness of its effect, not on an individual *per se* but on persons as interdependent units of society. A community is therefore defined as a group of people who are significantly affected by an action or a decision. Autonomy must then be qualified by the legitimate interests and expectations of others, as well as by economic constraints. In the medical context, the claims of autonomy, defined here as the right to redress, must be moderated so as to accommodate the sensitivities of others, including those of the doctor – who is also an autonomous agent. Personal autonomy must be measured against the needs of the society as a whole. For example, in an ideal world, a sick person should be able to demand the treatment of his choice. It is acknowledged that this is an impossible goal. Society itself demands a just distribution of resources and that cannot be realised in an ambience of unrestricted 'rights': we can only realise our autonomy within the framework provided by society.

C. Corrective or Distributive Justice as a Basis for Recovery in Clinical Negligence Cases

> Tort law is a mosaic in which the principles of corrective justice and distributive justice are interwoven.[83]

At one extreme one could opt for a social security system which allocates resources according to need and would not give priority to victims of iatrogenic harm.[84] Many corrective justice proponents reject the idea of no-fault schemes on the basis that they neglect the necessary moral recognition of responsibility. Moreover, public (or psychological) vindication is not provided at all by compensation systems such as personal insurance and social security, in which entitlement to compensation does not depend on establishing legal wrongdoing where the compensation is sought from and

[82] The discussion in this paragraph is drawn from Mason and Laurie, n 22, 7.
[83] *McFarlane v Tayside Health Board* [2000] 2AC 59 per Lord Steyn at 165.
[84] See Harris, n 39, 3. Also CMO, *Making Amends* n 2. A no-fault system is rejected for English law for several reasons including increased costs.

paid by persons in no way responsible for the loss suffered and where entitlement to compensation is determined by an administrative process conducted in private.[85]

Putting no-fault schemes to one side, I argue that despite the theoretical conflict, I would opt for a model of corrective justice as regards liability for the damage incurred and payment of damages for pecuniary loss, but look to distributive justice principles, which focus on the just distribution of burdens and losses amongst members of a society dependent on an NHS, when considering the merits of compensation for non-pecuniary loss. It is clear that there has been judicial concern regarding which principle of justice should prevail. Before considering *McFarlane*, the decision that parents of an unplanned but healthy child were no longer entitled to recover damages reflecting the costs of its maintenance, I will note the line of judicial argument in *Frost v Chief Constable of South Yorkshire Police* and the other cases arising from the Hillsborough disaster.[86]

1. The Hillsborough Cases: The Police, the Public and the Bereaved Relatives

Judges are increasingly prepared to discuss wider policy issues.[87] The House of Lords has given explicit recognition to distributive justice principles as reasons for limiting tort liability. *Frost v Chief Constable of South Yorkshire*[88] involved claims by police officers with respect to psychiatric injury suffered after helping victims at the Hillsborough disaster, where 96 spectators were crushed to death at a soccer match. The negligence of the officers' employers was held insufficient to ground recovery for pure psychiatric injury. Their Lordships expressed concern about the impact of a litigation explosion in the area of an employer's duties. There was also concern about the burden of damages and the impact upon crowded court lists. If the employer's duty were enlarged in this way the new principle would be available in many different situations, eg doctors and hospital workers who are exposed to the sight of grievous injuries and

[85] P Cane, *Atiyah's Accidents, Compensation and the Law*, 6th edn (Cambridge, Cambridge University Press, 2004), 361. Now see 7th edition (for publication details see n 3), Chapter 17 'The Functions of Compensation Systems'. This will be discussed more fully in Chapter 6 'Damages'.
[86] *Frost v Chief Constable of South Yorkshire Police* [1998] 3WLR 1509. Note: With the publication of The Report of the Hillsborough Independent Panel in September 2012 criticising the public services' response and responsibility for the disaster, the legal issues will be revisited.
[87] R Lewis, 'Insurance and the Tort System' (2005) 25 *Legal Studies* 1, 85 fn 48 for references.
[88] *Frost v Chief Constable of South Yorkshire* [1999] 2 AC 455.

suffering. This particular image of potentially far-reaching liability illustrates how heavily the floodgates argument weighed with Lord Steyn.[89]

It is also clear that their Lordships recognised that based on the rule of recovery it would be difficult to justify how it would be fair to award compensation to police officers[90] when it had already been refused to family members of those who had been killed or maimed at the disaster. Lord Hoffmann said that corrective justice '...has been abandoned in favour of a cautious pragmatism.'[91]

Lord Hoffmann put the dilemma of choosing between corrective and distributive justice as a basis for recovery for personal injury succinctly in *Alcock v Chief Constable of South Yorkshire Police:*[92]

> If one starts from the proposition that in principle the law of torts is there to give legal force to an Aristotelian system of corrective justice, then there is obviously no valid distinction to be drawn between physical and psychiatric injury....On the other hand, if one starts from the imperfect reality of the way the law of torts actually works, in which the vast majority of cases of injury and disability, both physical and psychiatric, go uncompensated because the persons (if any) who caused the damage were not negligent (a question which often involves very fine distinctions), or because the plaintiff lacks the evidence or the resources to prove to a court that they were negligent, or because the potential defendants happen to have no money, then questions of distributive justice tend to intrude themselves. Why should X receive generous compensation for his injury when Y receives nothing? Is the administration of so arbitrary and imperfect a system of compensation worth the very considerable cost?

The underlying issue in these cases was an attempt to limit the class of persons who could recover damages on the basis of pure psychiatric injury not linked to physical injury. The 'solution' was a convoluted and medically unsound division of victims as primary and secondary and the conditions that each class must show in order to qualify

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[89] *White v Chief Constable of South Yorkshire Police* [1999] AC 455 in the House of Lords.

[90] 'The police officers have the benefit of statutory scheme which permits them to retire on pension. In that sense they are already better off than bereaved relatives who were not allowed to recover in the *Alcock* case [1992] 1 AC 310. The claim of the police officers on our sympathy and the justice of the case is great but not as great as that of others to whom the law denies redress.' At 255 Lord Steyn.

[91] *Alcock v Chief Constable of South Yorkshire Police:* [1992] AC 310 at 503 at 1530H–1551B. For fuller quote from Lord Hoffmann see Mason n 52, 4.

[92] *Alcock v Chief Constable of South Yorkshire Police:* [1992] AC 310 at 503 in relation to competing proposals to scrap all control mechanisms regarding claims for psychiatric damage or alternatively to abolish recovery for psychiatric injury altogether, ibid, page 4.

for relief.[93] In the end we are left with a sense of 'weary resignation'[94] that pervades the majority speeches in *White*. Lord Hoffmann characterised the underlying concern in *White* as one of fairness between citizens. Was liability in negligence essentially about corrective justice – a principled 'righting of wrongs' by the wrongdoer within established legal rules – or should broader considerations of policy and social justice be allowed to influence or determine outcomes? Though historically the pursuit of corrective justice held sway and is still often portrayed as the dominant function,[95] considerations of what is sometimes described as 'distributive justice' increasingly intrude.[96] Harvey Teff has argued, rightly I think, that in negligence which has its primary roots in the principle of corrective justice, the principles of distributive justice are effectively built into the formulation of the duty of care, via the 'fair, just and reasonable' requirement.[97]

For Lord Steyn, 'reasons of distributive justice were *decisive'*.[98] I would take issue with the somewhat grandiose use of the term 'distributive justice' as a rationale for the decision. As a concept, distributive justice is most appropriately understood in systemic terms as a model for achieving greater fairness in the overall pattern of resource allocation. By contrast, the primary/secondary victims classification in *White* merely limits the class of those who can obtain a remedy within the framework of a system rooted in corrective justice. As Lord Steyn observes:

> In an ideal world all those who have suffered as a result of the negligence ought to be compensated. But we do not live in Utopia: we live in a practical world where the tort system imposes limits to the classes of claims that rank for consideration as well as to the heads of recoverable damages. This results, of course, in imperfect justice but it is by and large the best that the common law can do.[99]

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[93] Chapter 'The Unfulfilled Promise of 'Law Marching with Medicine' in H Teff, *Causing Psychiatric and Emotional Harm: Reshaping the Boundaries of Legal Liability* (Oxford, Hart Publishing 2009), 82.
[94] Ibid, 93.
[95] See, eg *X (minors) v Bedfordshire County Council* [1995] 2 AC 633 per Lord Browne-Wilkinson.
[96] See *White* per Lord Hoffman. 'The truth is that tort law is a mosaic in which the principles of corrective and distributive justice are interwoven. And in situations of uncertainty and difficulty a choice has to be made between the two approaches.' *McFarlane v Tayside Health Board* [2000] 2 AC 59, per Lord Steyn at 83.
[97] Teff, n 93*,* 92.
[98] Lord Steyn, *Perspectives of Corrective and Distributive Justice in Tort Law*: John Maurice Kelly Memorial Lecture University College Dublin, Faculty of Law (2002) 7 cited by Teff, ibid, 92 and with emphasis added by Teff.
[99] Lord Steyn in *White* n 89 at 248.

The reality seems to be that there is an irresolvable tension between the merits of both philosophical paradigms when it comes to compensating victims of medical accidents. In clinical negligence and psychiatric injury cases, victims (and their relatives and friends) are frequently angry and resentful. It is difficult for them to accept judgments rooted not in clear corrective justice terms but rather in considerations of distributive justice that are frequently veiled.

2. Wrongful Pregnancy Cases: Who Pays for Baby?

The stories of parents bringing wrongful conception and birth suits against health authorities raise familiar scenarios – clinical mishaps in family planning techniques including negligently performed sterilisations and, in the case of wrongful birth, negligent failures in genetic counselling, whether actual diagnosis or information provision. Claiming that in the absence of such negligent treatment the 'unwanted child' would not have been born,[100] parents have sought damages under two heads: firstly, for the pain and suffering attendant on the 'personal injury' of pregnancy and birth and secondly, for the costs of child maintenance. While for over a decade parents were able to seek both heads of damages from courts where clinical negligence resulted in the birth of a healthy or disabled child, in 1999, the adjudication by the House of Lords in *McFarlane* brought one dimension of this trend to a close.[101]

a) McFarlane and the *'Healthy Child'*

> Fortunately or unfortunately, she gave birth to a normal, healthy boy…The phrase 'fortunately or unfortunately' encapsulates the most part of the legal argument which has surrounded the plaintiff's claim for damages.[102]

In *McFarlane* the pursuers claimed compensation for the costs arising from the gestation and birth of an unwanted healthy child conceived as a consequence of the defender's negligence. The House of Lords held that the McFarlanes could recover general damages for the pain, discomfort and inconvenience as well as the costs arising

[100] See N Priaulx, 'Damages for the "Unwanted" Child: Time for a Rethink?' (2005) 75 *Medico –Legal Journal* 4, 152 fn 5.
[101] The discussion which follows is confined to the issue of damages for maintenance of the healthy child and not the question of children or parents with disabilities.
[102] *Dale v Bloomsbury AHA* [1983] 2 All ER 522, [1983] 1 WLR 1098, per Jupp J.

out of the pregnancy.[103] However, although not taking issue with the mother's claim (Lord Millett dissenting on this point), their Lordships utilised a wide variety of legal techniques in order to unanimously deny the more substantial claim for child maintenance in the case of the *healthy* child. The House of Lords, in *McFarlane*, overturned what had been thought to be settled law since the Court of Appeal judgment in *Emeh v Kensington, Chelsea and Westminster Area Health Authority.*[104] While the judgment is less than straightforward since their Lordships gave different reasons for their decisions, the general thrust of *McFarlane* was this: if parents had suffered any loss, then this was pure economic loss which was not recoverable.[105]

The significance of *McFarlane* for present purposes concerns the question of whether damages, paid from a straitened NHS budget, should be available for the *birth and upbringing* of a *healthy* child. The case addresses in sharp relief the tension between the demands of corrective and distributive justice. The argument for corrective justice and legal principle is that the couple had an initially unwanted child due to the negligent advice provided by someone who owed them a duty of care; their reasons for avoiding a further parentage were largely economic and to return them to the position in which they would have been in the absence of negligence involved reparation of the costs of maintaining that child. When it comes to consideration of distributive justice, arguments of a moral nature intrude, namely, whether the birth of a healthy child should not be considered an injury on the grounds of public policy, whether it is wrong to compensate people for an event many other couples have been seeking unsuccessfully and whether it is undesirable for a child to grow up to discover it was so unwanted that its parents did not pay for its upkeep.[106]

What losses can be compensated in the circumstances the McFarlanes were in? As noted above, the action in negligence raised against the Health Board was in two parts – the 'mother's claim' in respect of pain and suffering due to pregnancy and childbirth and the 'parents' claim' for the upkeep of the child until the age of majority.

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[103] The 'mother's claim'.
[104] *Emeh v Kensington, Chelsea and Westminster Area Health Authority* [1985] QB 1012.
[105] For details of the judgments see L Hoyano, 'Misconceptions about Wrongful Conception' (2002) 65 *Modern Law Review* 883 and KJ Mason, *The Troubled Pregnancy*, (Cambridge, Cambridge University Press, 2007).
[106] Mason, ibid, 106.

i. 'The mother's claim'

Mrs McFarlane claimed a sum of £10,000 in respect of pain, suffering and distress resulting from the unwanted pregnancy. Lord Steyn's reasons for allowing this aspect of the claim allude to issues of corrective and distributive justice:

> The claim for solatium simply alleges that Mrs McFarlane became pregnant and had to undergo a pregnancy and confinement and the pain and distress of giving birth to the …child. It will be recalled that I have already rejected the argument that Mrs McFarlane suffered no personal injury. The constituent elements of a claim in delict are present. The considerations of distributive justice which militated against the claim for the cost of bringing up Catherine do not apply to the claim for a solatium.[107]

A majority of the House of Lords allowed Mrs McFarlane's claim for the pain and suffering associated with pregnancy and childbirth and for consequential financial losses, such as clothing and loss of earnings. Lord Millet's minority view on this point was that the two claims were dependent upon each other and both claims should be denied if one was unacceptable.[108]

ii. 'The parents' claim'

In *McFarlane*, the House of Lords confirmed that pregnancy and childbirth could qualify as personal injuries for the purposes of an action in negligence. The maintenance costs of a healthy child, however, while foreseeable, were not recoverable. Although the Law Lords' reasons differed, I argue that underpinning them all was a concern that:

> To award potentially very large sums of damages to the parents of a normal and healthy child against a National Health Service always in need of funds to meet pressing demands would rightly offend the community's sense of how public resources should be allocated.[109]

Lord Slynn, when considering the extent of the duty of care and of liability for economic loss, applied the *Caparo*[110] standard: 'I consider that it is not fair, just or reasonable to impose on the doctor or his employer liability for the consequential

[107] *McFarlane* n 83.
[108] Mason, n 105, 114.
[109] *Rees v Darlington Memorial Hospital NHS Trust* [2004] AC 309, [2003] 4 All ER 987 at [6] per Lord Bingham. See also Lord Nicholls at [16].
[110] *Caparo Industries plc v Dickman* [1990] 2 AC 605, [1990] 1 All ER 568.

responsibilities imposed on or accepted by the parents to bring up a child'. Lord Slynn suggests that a line must be drawn before such losses are recoverable – but how fair, just or reasonable does it seem to the parents?[111]

Lord Steyn's judgment more directly addresses the issue of corrective and distributive justice. While stating that from the perspective of corrective justice the parents' claim for the cost of bringing up Catherine should succeed, when focusing on the 'just distribution of burdens and losses among members of society', Lord Steyn decided that the parents of an unwanted but healthy child should not be able to sue the doctor or hospital for compensation equivalent to the cost of bringing up a child for the years of her minority. Lord Steyn relied on the reasoning in *Frost v Chief Constable of South Yorkshire Police*[112] that it would be morally unacceptable if the law denied a remedy to bereaved relatives but granted it to police officers who were on duty. I find Lord Steyn's appeal to public opinion[113] unconvincing because he saw this as a 'moral' rather than 'legal' argument and accepted that within tort law rules the claim would not satisfy the requirements of being fair, just and reasonable.[114]

Lord Hope thought that, since the benefits associated with a healthy child were incalculable, it was illogical to attempt an assessment of the net economic loss sustained by the child's parents. One reason was the difficulty of offsetting financial costs with emotional benefits.[115] Lord Clyde was struck by the disproportion between the surgeon's culpability and the level of damages that would be required for the full costs of the child's upbringing. He considered the extent of liability that the defenders could reasonably have anticipated and opined that the cost of the child's upbringing would be 'way beyond this'. Lord Millett objected to this 'proportionality argument' on the grounds that damages in tort are not based on the 'gravity' of fault but rather, are intended to put the claimant in the pre-tortious position. Lord Millett returned to the

[111] See Mason, n 105, 118 for full discussion of the judgments.
[112] *Frost v Chief Constable of South Yorkshire Police* [1998] 3 WLR 1509 see Hillsborough cases above.
[113] The 'distributive justice argument', namely, whether the commuters on London Underground would find it acceptable to allow such a claim.
[114] Per Lord Steyn at 979 in *MacFarlane* n 76.
[115] The 'offset argument'. Costs could in fact be objectively quantified. See M Donnelly, 'The Injury of Parenthood: The Tort of Wrongful Conception' (1997) 48 *Northern Ireland Legal Quarterly* 1, 10.

reasoning in the index English case[116] in holding that the law must accept the birth of a healthy baby as a blessing.[117]

While accepting the mother's claim, the costs of the child's upbringing were, according to the majority of the House of Lords, pure economic loss and subject to the special rules of recovery, namely the '*Caparo* test' of foreseeability, proximity and that it should be fair, just and reasonable to impose a duty of care in these circumstances. A majority of the House of Lords rejected the McFarlanes' claim on the third limb of the test, namely that imposing liability on the Health Authority for the costs of their healthy child's upbringing would not be fair, just and reasonable.

The rejection by the Lords of the McFarlane claim is predicated on a concern that scarce NHS resources should not be diverted from their primary purpose of healthcare. However, the courts are not the forum where resources are allocated. In order to come to an equitable result, their Lordships have distorted traditional tort principles. The 'mother's claim' was for a 'limited recovery' and therefore unproblematic. However, the upbringing costs of a healthy child, which in other cases have included the costs of private education,[118] were clearly seen as a step too far. Lord Millett's suggestion of a 'conventional sum' of £5,000 to compensate for the wrongful interference with their freedom to limit the size of the family,[119] could be seen as an honest marker that a wrong was done and might have been a more elegant and honest solution.[120]

b) Parkinson – the *'Disabled Child'* and Rees - the *'Disabled Parent'*

The decision in *McFarlane* is unsatisfactory, a significant problem being the lack of clarity about legal policy and principle. *McFarlane* does not straightforwardly apply to cases where either the child or the parent is disabled and the House in *McFarlane* deliberately left open the possibility of recompense for the upkeep of an unexpected 'disabled' child.

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[116] *Udale v Bloomsbury Health Authority* [1983] 2 All ER 531.
[117] However, Lord Millett did also suggest the payment of a conventional sum for general damages, not upbringing.
[118] *Benarr v. Kettering Health Authority* [1988] N.L.J. 179
[119] The figure could be re-configured to represent a sum for maintenance.
[120] For fuller discussion see Jackson n 15, 750–755. The issue of a conventional sum was re-visited subsequently in *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52.

In *Parkinson v St James and Seacroft University Hospital NHS Trust*[121] an attempt to entrench the possible exception for disabled children firmly within the law was successful. In this case a woman gave birth to a disabled child following an admittedly negligent sterilisation operation. Although it was in fact agreed that the child's disability was not attributable to a breach of duty on the defendant's part, the Court of Appeal made an exception and agreed to an entitlement to the extra costs over and above the expenses associated with bringing up a healthy child. The exception has been seen as a 'tug of sympathy' for the claimants rather than a principled exception.[122] However, Brooke LJ pointed out that parents in a similar position had been able to recover damages for some 15 years following *Emeh v Kensington and Chelsea and Westminster Area Health Authority*[123] and that both the 'fair, just and reasonable' test and the principles of distributive justice would be satisfied if the award was limited to the special costs associated with the disability. He was supported in a powerful speech by Hale LJ who started from the premise that to cause a woman to become pregnant against her will was an invasion of her bodily integrity. Hale LJ could find nothing unusual or contrary to legal principle in awarding damages in such a case on the grounds that the caring role persists throughout childhood. Admitting damages limited to the restitution of costs beyond those involved in bringing up a normal child gave no offence to those with disability and simply acknowledged that the costs in the event of disability were greater than in the case of normality – put another way, the 'deemed equilibrium' between the benefits derived from and the costs of maintaining an uncovenanted healthy child that underpins the *McFarlane* decision is distorted to an extent that is determined by the degree of disability in an unhealthy child.[124] Although I welcome the more generous outcome in *Parkinson*, I agree with Mason and Laurie[125] that there remains a logical inconsistency between the outcomes of the two cases. Hale LJ's arguments regarding bodily invasion can be equally applied to the birth of a 'healthy' uncovenanted child; additionally, in most cases, the fact that the disability was not caused by the breach dilutes the moral imperative for compensation.[126]

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[121] *Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 530; [2001] 3 All ER 97.
[122] See Hoyano, n 105.
[123] *Emeh v Kensington and Chelsea and Westminster Area Health Authority* [1985] QB 1012, [1984] 3 All ER 1044, CA.
[124] See Mason and Laurie, n 22, 179.
[125] Ibid.
[126] See also Jackson, n 120, 740.

c) Rees: the *'Disabled Parent'*

The House of Lords revisited the issues again in *Rees v Darlington Memorial Hospital NHS Trust,*[127] a case concerning a disabled parent and a healthy child. In this case, as a result of a negligently performed sterilisation operation, a healthy child was born to a woman who was severely visually handicapped. The mother claimed damages not only for the pain and discomfort of pregnancy and childbirth 'the mother's claim', but also for the additional costs incurred as a result of her disability. The Court of Appeal by a 2 to 1 majority allowed recovery on the grounds that the claimant's case could be distinguished from *McFarlane* because *McFarlane* only applied to healthy parents. Waller LJ in a powerful dissenting judgment argued that whether the birth of an unwanted child is a 'disaster' will often depend more upon the resources and support available to the mother than on whether she happens to be disabled.[128] On appeal, the House of Lords reconsidered its judgment in *McFarlane.* Despite trenchant criticism of *McFarlane* in a similar case heard in the High Court of Australia,[129] the seven Law Lords unanimously declined to revisit the judgment in *McFarlane* largely on the basis of consistency of the law. In considering whether an exception should be made where the mother was disabled, the House of Lords was divided. By a 4 to 3 majority it held that *Rees* could not be distinguished: the child was healthy so *McFarlane* applied. Therefore there was no recovery for any of the costs associated with the child's upbringing. In contrast, the dissenting judges would have allowed Karina Rees to recover for the extra costs associated with her disability. Nevertheless, the majority added a 'significant gloss'. Lord Bingham explicitly questioned 'the fairness of a rule which denies the victim of a legal wrong any recompense at all beyond an award immediately related to the unwanted pregnancy and birth…'. He then suggested a conventional sum of £15,000 'which would not be and would not be intended to be compensatory…It would afford some measure of recognition of the wrong done.'[130] Arguably, this decision shows the tension between adhering to the ordinary rules of tort law based on corrective justice principles and the requirement of distributive justice, namely: that giving the claimant full compensation for all her losses would undermine the capacity of the NHS to provide adequate healthcare to the rest of the population.

[127] *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52.
[128] *Rees v Darlington Memorial Hospital NHS Trust* [2002] EWCA Civ 88. See Jackson, n 120*,* 743.
[129] *Cattanach v Melchior* [2003] HCA 38. See Jackson, ibid, for details.
[130] Jackson, n 120, 747.

Would a conventional sum which recognised that a wrong had been done to them but does not attempt to provide full compensation be a good compromise? I can see this as a reasonable solution to the problems of a stretched healthcare budget but Mark Lunney has significant reservations:

> It is risky because it may end up pleasing no one, except perhaps the NHS. Given the potential costs involved in raising a child, the parents of a healthy child may still feel hard done by. Disabled parents may feel aggrieved because the comparatively small award is unlikely to meet the additional costs incurred because of their disability. Those in favour of a full award in line with corrective justice principles may feel that the solution fails to do justice and those who believe *McFarlane* was a wholly just decision may feel that the judgment has been undermined.[131]

In the context of claims for clinical negligence, the various 'solutions' adopted in both *McFarlane* and *Rees* are undoubtedly anomalous. Creating a partial immunity to the NHS against liability for wrongful conception and birth suits must now raise difficult questions for *all* clinical negligence claims, particularly those with a large element of 'pure economic loss', as to which are the most deserving of compensation and which are not. If one considers that such judgements are better left for Parliament than the judiciary, then the reproductive torts now require a serious rethink.[132]

D. Corrective and Distributive Justice: Damages and the NHS

The conundrum is the question of the relevance and application of distributive justice in tort law, which is primarily a system of corrective justice. It is arguable that a system of corrective justice in the sphere of clinical negligence is predicated on distributive justice principles applied to outcome-responsibility.[133] Outcome-responsibility for harm to another does not by itself create a duty to compensate. However, it serves as a basis on which the law can erect a duty to compensate if there is a reason to treat the harm suffered as the infringement of a right. The *form* that our responsibility for an outcome takes remains an open question; an apology will often be enough. In other cases the

[131] M Lunney, 'A Right Old Mess: *Rees v Darlington Health Authority*' (2004) 1 *University of New England Law Journal (Australia)* 145.
[132] Priaulx, n 100, 152 at 161.
[133] Honoré, n 20, 73 at 83.

state may impose tort liability to make good the loss, provided that to do so is not inconsistent with maintaining competing crucial principles.[134]

Any limitation on liability is analysable in terms of distributive justice. The 'fair, just or reasonable' criterion, which has become an accepted part of English negligence law, is now being acknowledged as expressing distributive justice.[135] In *Rees*, Lord Steyn characterised the ratio of *McFarlane* as reliant on the impossibility of weighing the benefits and detriments of the birth of a healthy child and Lord Millett opined that it would be 'morally offensive' for society 'to regard a normal healthy child as more trouble and expense than it is worth'. When coupled with the principle of distributive justice, or the 'fair, just or reasonable' test – which is arguably just distributive justice by another name – the result was that the maintenance costs of a healthy child could not be recovered.[136] It is impossible from this to determine the exact end point by which a fair distribution should be measured. However, it is noted that the subsequent Court of Appeal hearings of *Parkinson* and *Rees* were determined on the basis of need.[137] This reliance on a needs-based distributive justice argument has been undermined by the majority's decision in *Rees*, which applies in all cases where the child is healthy. If that point is considered in conjunction with the previous argument about the lack of balance to be tipped by the extra costs arising from a disability, it is arguable that in order to be consistent, parents should no longer be able to recover where the child is disabled.[138]

There remains a problem with determining the optimum distribution of losses and burdens within society.[139] Honoré argues that the two theories meet because corrective justice depends on distributive justice, corrective justice being a genuine form of justice only because the just distribution of risks distributes throughout society the risks of harm attributable to human conduct.[140] This just distribution of risks requires people to bear the risk of harming others by their conduct even when they are not at fault in doing so. In the end, the justification of tort liability both against the harm-doer personally and

[134] Ibid, in particular the necessity of distributive justice in the case of the NHS.
[135] A Maclean, 'An Alexandrian Approach to The Knotty Problem of Wrongful Pregnancy: *Rees v Darlington Memorial Hospital NHS Trust* in the House of Lords' [2004] 3 Web JCLI, http://webjcli.ncl.ac.uk/2004/issue3/maclean3.html> This is not true in Australian law, which has rejected the *Caparo* test: *Melchior v Cattanach* [2003] HCA 38, at [121–122] per Kirby J.
[136] *Rees v Darlington Memorial Hospital NHS Trust* [2004] 1 AC 309, 325 [28–29].
[137] Hale LJ's argument in, *Rees* n 128 [22].
[138] MacLean, n 134.
[139] Ibid.
[140] See Honoré, n 133, 84 for fuller discussion.

against secondary defendants, such as health authorities held to be vicariously liable, rests on both corrective and distributive justice.

The question of the extent of entitlement to financial redress is particularly acute when the defendant is the communal NHS. I accept Tony Honoré's construction that clinical negligence law is a system of corrective justice predicated on distributive justice principles applied to outcome-responsibility. Hence, in the particular context of the NHS, entitlement to redress for loss is perhaps justifiably finite. I will argue that non-pecuniary loss can be redressed in ways alternative to damages. My argument is not solely based on the practical issue of the NHS finances, although that weighs heavily, but on the point that these intangible, uncommodifiable losses require a different approach. In the following chapter[141] I will address the issue of what victims of iatrogenic harm seek from redress for pecuniary and non-pecuniary loss. In a later chapter[142] I will consider the question of the extent to which damages can compensate for pecuniary and non-pecuniary losses.

III. CONCLUSION: FORMS OF REDRESS

What would an adequate, fair, rational and just system of compensation for iatrogenic harm within the confines of a national health service look like?[143] In corrective justice terms it is incumbent upon the NHS to compensate victims of iatrogenic harm. In pragmatic terms today it is the NHS Litigation Authority (hereinafter 'NHSLA'), a public body answerable to HM Treasury, which provides the damages. Whereas this may compensate for pecuniary losses, I would argue that this payment is not sufficient in offering succour for the emotional need to know what happened and for an acknowledgement from the negligent party, albeit that the injury was unintentional. The tensions between the theories of corrective and distributive justice have been explored. The roles of fault and cost have been addressed with respect to how they influence both the theory and practice of the law pertaining to clinical negligence. In essence I argue that the principle of corrective justice fulfils the moral imperative of redress for iatrogenic harm to a specific patient but that the principles of distributive justice are

[141] Chapter 2 'What Patients Seek from Redress', below.
[142] Part II Chapter 6 'Damages', below.
[143] '…maintaining the *welfare state compromise* of 1945'. J Harrington, 'Law's Faith in Medicine: Utopia and Its Discontents', Paper presented at *Modern Law Review Seminar on Health, Law, Faiths and Beliefs: New Dilemmas – New Perspectives* held at University of Leicester (26 May, 2006).

called upon when analysing limitations of liability within the Health Service. After a complementary chapter looking at patients' wishes from redress,[144] the thesis is divided into two parts, one looking at medical negligence litigation, the second at redress within the NHS.

A. Civil Litigation and the NHS Complaints Procedure

The legal and the Health Service routes to justice are quite different. The former offers damages, the latter explanations, apologies where appropriate and undertakings to repair. Damages operate as compensation, as a marker of wrongdoing and as acknowledgement that redress is needed. Damages also address needs and this might be regarded as the most significant aspect of damages. Explanations and apologies act as different types of reparation. They address the emotional and moral pain suffered by the victim and his family. However, as will be shown, access to either system presents difficulties.[145] Patients and their families may have to endure repeated hearings in their efforts to obtain information and justice.[146] Until recently, the two systems have been mutually exclusive in that recourse to the law barred one from using the NHS complaints procedure. The NHS Redress Act 2006 intended to provide a framework for the resolution of clinical negligence disputes by combining features of the legal and healthcare mechanisms is not yet fully functioning but will be considered in a subsequent chapter.[147] I will argue that both the legal and the NHS systems, while offering some remedies, have their drawbacks. This is especially true for those seeking clarification of the adverse event. I will argue that it might be helpful to consider initiatives in Australia which offer open disclosure and what is referred to as full apologies.[148] These are not easy options but if they offer effective redress they will prove to be options worth exploring.

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[144] Chapter 2 below.
[145] Part II Chapter 3 'Funding Litigation' and Part III Redress Within the NHS Chapter 7 'History of the NHS Complaints Process', below.
[146] Ibid.
[147] Part III Chapter 8 'NHS Redress Act 2006'. Note: although in *Making Amends* it was mooted that a duty of candour might be imposed in the forthcoming NHS Redress Act 2006, this did not materialise. See M Brazier & E Cave, *Medicine, Patients and The Law* 5th edn (Harmondsworth, Penguin, 2007), 270 on the NHS Redress Act 2006.
[148] RAM Iedema, 'The National Open Disclosure Pilot: Evaluation of a Policy Implementation Initiative' (2008) 188 *Medical Journal of Australia* 7, 397–400 and P Vines, 'The Power of Apology: Mercy, Forgiveness or Corrective Justice in the Civil Liability Arena?' (2007) 1 *Public Space: The Journal of Law and Social Justice* 1, 1–50. See also Part III Chapter 9 'Effective Redress'.

CHAPTER 2

WHAT DO PATIENTS SEEK FROM REDRESS?

Studies of patients and families considering or involved in litigation suggest the importance of explanation and apology, but findings from such studies are suggestive rather than conclusive, and correlation and causation are not yet established.[1]

Should we continue with fault as a basis of compensation? Or is the link between fault and payment forged by deeply felt but …dysfunctional drives for accountability and, let's use the word, revenge? It is difficult to explain the persistence of the Anglo-American fault-based tort system as anything other than its having been built on an atavistic foundation of retributive, rather than distributive justice.[2]

[1] KM Mazor, SR Simon, JH and JH Gurwitz, 'Communicating with Patients about Medical Errors: A Review of the Literature' (2004) 164 *Archives of Internal Medicine* 1690–1697.

[2] EA Dauer, 'Medical Injury, Patients' Claims and the Effects of Government Responses in Anglo-American Legal Systems' (2011) 20 *British Medical Journal Quality and Safety* 735–737.

I. INTRODUCTION

The question of what iatrogenically injured patients and their families might seek from redress is a complicated one. There is no solution offering *restitutio in integrum*; therefore most forms of redress are rendered second best from the start. Historically, four themes have been mooted: restoration, including financial compensation or another intervention to 'make the patient whole again'; correction, such as a system change or competence review to protect future patients; communication, which may include an explanation, expression of responsibility, or apology; and sanction, including professional discipline or another form of punitive action.[3] More recently, these notions have been considered in more nuanced ways.[4]

Due to the increasing sophistication of medical law and the Human Rights Act (hereinafter 'HRA') 1998, there are now a myriad of initiatives designed to address the 'tangle of motives behind a patient's or family's decision to take legal action following medical injury, money only representing one of them'.[5]

In chapter 1,[6] I argued that on the basis of corrective justice principles, iatrogenically injured patients have an entitlement to redress and compensation against the tortfeasor. In this chapter, I will address what is known about the motivations of patients who suffer an adverse event, why some become complainants and others claimants[7] and why some choose not to sue. I then turn to the issues of open disclosure, apologies and communication, seemingly self-evident requirements for satisfactory redress and yet rarely forthcoming. I will consider the impediments to the straightforward solution of openness from the medical providers. In addition, consideration will be given to recent initiatives in England aimed at facilitating open disclosure, legal duty of candour and incidence reporting. In conclusion, this chapter sets out what patients might wish from redress. In the final chapter of the thesis,[8] I will evaluate the 'expectations gap': the

[3] M Bismark and E Dauer, 'Motivations for Medico-Legal Action – Lessons From New Zealand' (2006) 27 *The Journal of Legal Medicine* 55. Issues regarding professional sanctions and discipline will be addressed in Part III Redress within the NHS below.
[4] M Bismark, MJ Spittal, AJ Gogos, RL Gruen and DM Studdert, 'Remedies Sought and Obtained in Healthcare Complaints' (2011) 20 *British Medical Journal Quality and Safety* 806–810 and Dauer (n 2).
[5] Bismark and Dauer (n 3).
[6] Chapter 1 'Corrective Justice and Entitlement to Redress Within the NHS' above.
[7] Bismark, Spittal et al (n 4).
[8] Chapter 9 'Effective Redress' below.

discrepancy between what complainants/claimants want and what they in fact get out of the redress processes.[9] Unfortunately, except for low-value claims,[10] there is as yet no integrated response system to address the wishes of claimants, both financial and otherwise. This chapter lays the foundation for the rest of the thesis,[11] which analyses redress available to victims both through the English legal system and the extralegal methods of pursuing complaints through the English NHS structures.[12] I will argue that, apart from pecuniary loss, restoration through monetary means is illusory. Therefore, within the strictures of a universal health service, both the needs of patients and their families and the demands of distributive justice are better served by improved extralegal initiatives.[13]

II. PATIENTS' COMPLEX DESIRES

In a landmark paper, four aspects of redress issues for iatrogenically injured patients were put forward, namely: restoration, correction, communication and sanction.[14] Although these will be discussed discretely, patients and families often seek an amalgam of all four.

A more sophisticated view would show that there is little that is intrinsic or inevitable about people's needs and expectations following an injurious event. What people want and expect is as much a function of environmental variables as it is of objective injury, loss or pain.[15] Sally Lloyd-Bostock,[16] writing from the perspective of the psychology of legal decision-making and the social psychology of legal disputes, developed what she termed 'attribution theory' to link injury with behaviour, specifically 'claiming behaviour'. An individual's journey from the fact of an injury to the making (or not making) of a claim is an untidy psychological process. In outline, it can be described as

[9] Bismark, Spittal et al (n 4).
[10] Clinical negligence claim worth less than £1,000 *small claims track* should not result in proceedings. Brazier, M and Cave, E *Medicine, Patients and The Law*, 5th edn (Harmondsworth, Penguin, 2011), 228.
[11] Themes addressed in this chapter will be expanded upon throughout the thesis.
[12] Where applicable, references will be made to initiatives in other Commonwealth jurisdictions.
[13] 'If damages become payable, then that means there is a correspondingly reduced amount available for the maintenance of wards and equipment, the purchase of drugs or the provision of treatment. A medium sized award therefore may be crudely translated into ten fewer hip replacements.' A Merry and A McCall Smith, *Errors, Medicine and The Law* (Cambridge, Cambridge University Press, 2001), 212.
[14] Bismark and Dauer (n 3).
[15] S Lloyd-Bostock 'The Ordinary Man and the Psychology of Attributing Causes and Responsibility' (1979) 42 *Modern Law Review*, 143–168. See Dauer (n 2), 735 for exposition of 'attribution theory'.
[16] Ibid.

a cascade of perceptions and decisions: first, recognising the fact that one has been injured; second, realising that the injury was caused by someone else; third, assessing that cause as a matter of fault or wrongdoing on the tortfeasor's part; next, concluding that some sort of accountability is called for; and from there sorting through all of the permutations of seeking satisfaction by selecting a remedy, the latter dependant on the remedial pathways known to be available.

The discussion below is to be seen in the context of these complexities and in the framework of dispute resolution choices people make in response to unsatisfactory medical experiences.[17]

A. Restoration: How Far Can Money Take Us?

Restoration is concerned with the attempt to restore the injured person to 'wholeness' and focuses on the needs of the victim rather than the impact on the tortfeasor. In this context, restoration typically involves monetary compensation. To the extent that damages represent *pecuniary* loss, restoration is possible. For the intangible losses, damages represent *means replacing compensation* or *ends replacing compensation.*[18] For present purposes these can be defined as substitute but incomplete compensation. Traditional litigation provides only money, infrequently, slowly and at considerable emotional and psychological expense.[19] Injured patients, however, report the need for other things, as noted: restoration (more broadly than cash); sanction (accountability for erring providers); communication (disclosure, explanation, apology); and, perhaps most significantly, correction (steps taken to assure the error is not repeated).[20] Money is a poor substitute for these other concerns and the legal system is used for a variety of

[17] ML May and DB Stengel, (1990) "Who sues their doctors? How patients handle medical grievances" *Law and Society Review*, 24, 103 at 106. 'Patients may *lump it; exit* by changing doctors; *make a claim* by confronting doctor with a complaint; *engage in disputing* taking the grievance to a non-legal forum; and/or *engage in disputing* involving a lawyer and then decide to sue or not sue'.
[18] Chapter 6 'Damages' below.
[19] See Part II 'Medical Negligence Litigation' below for analysis of the difficulties claimants face in pursuing litigation. Outcome of claims for medical negligence 2001–2011 NHSLA Factsheet August 2011: 37.69% abandoned by claimant; 45% settled out of court; 3.16% damages approved and set by court; yet to settle 14.14%. For the majority of claimants stressful and expensive litigation ends in disappointment. Research indicates that even where claimants are awarded damages, many remain dissatisfied, lacking an explanation, apology or assurance that the same thing will not be repeated. L Mulcahy, *Disputing Doctors: The Socio-Legal Dynamics of Complaints about Medical Care* (Maidenhead, Open University Press, 2003), 96.
[20] Dauer (n 2).

reasons, some of which it is not intended to serve.[21] However, the other systems of recourse, complaints,[22] referral to the Ombudsman or Commissioner, offer only non-monetary remedies.[23] Confining ourselves for the moment to requests for restoration in monetary terms, the most recent study of remedies sought and obtained in healthcare complaints[24] noted that the vast majority (87 per cent) of conciliated complaints included a request for restoration. This finding, consistent with similar research, identified this as an important outcome for many patients and families, particularly those who have suffered serious financial consequences as a result of medical injury.[25] Compensation is usually a determining factor for those suing on behalf of a relative (often a dependent child), but it is less important to the bereaved – who in any case receive small damages. Compensation is crucial for actual losses or to provide care in the future for an injured person, especially in jurisdictions which cannot assure future care through state welfare systems.[26]

1. Claimants

Because patients have such complex needs for redress, it is difficult to distinguish precise motivations which determine whether a patient takes the path of complaint and/or litigation. One study from New Zealand, where there are two well-established medico-legal paths, one leading to monetary compensation and the other to non-monetary forms of accountability, compared the form of accountability sought by patients and their families following an adverse event.[27] They noted that the odds that patients would seek compensation were significantly increased if they were in their prime working years or had a permanent disability as a result of their injury. Lost wages, serious injury and financial necessities, particularly if there are dependents, were also significant factors. It appears that there is a threshold with respect to bearable monetary losses due to injury. Beyond the threshold, the need for monetary

[21] Bismark and Dauer (n 3).
[22] Australia, New Zealand and England have responded to the need for redress apart from money by creating health complaint commissions empowered to deliver a broader and more responsive array of remedies. However, patient dissatisfaction is still significant. Dauer (n 2).
[23] Ibid.
[24] Bismark, Spittal et al (n 4), 808.
[25] M Bismark, E Dauer, R Paterson, et al 'Accountability Sought by Patients Following Adverse Events from Medical Care: The New Zealand Experience' (2006) 175 *Canadian Medical Association Journal* 889–94.
[26] C Vincent, A Phillips and M Young, (1994) 'Why do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action' 343 *The Lancet*, 1609.
[27] Bismark, Dauer, Paterson, et al (n 25).

compensation may become more pressing, whatever concerns the patient may have. As important as corrective action and improved communication may be, they cannot pay the bills. Another consideration for claimants is that medico-legal systems based on malpractice litigation allow few outlets for achieving non-monetary goals such as clinical review and finding out what occurred.[28] In these cases, money serves as a proxy.[29]

In conclusion, I fully support financial redress as compensation for pecuniary loss and argue that corrective justice principles require this even from a universal health service, which has to be held to the same account as the private or voluntary health sectors. Although restoration was included as a request for the majority of conciliated cases, it stood alone as a remedy sought in only 25 per cent of the complaints in this study of Anglo-American legal systems.[30] Litigation, ostensibly for compensation, may also be motivated by anger, perceptions of poor physician-patient communication and encouragement by families.[31] I argue that these other significant aspects of harm following adverse outcomes should be compensated by non-monetary remedies which specifically address them. I now turn to these.

2. Complainants

The issues raised by complainants in a further study, conducted in England, are remarkably consistent with the wishes expressed in studies in other commonwealth countries.[32] The most commonly sought form of non-monetary accountability, raised by 50 per cent of complainants, was the desire for corrective measures to address the causes of harm. That aspiration by patients and relatives to prevent future incidents can be seen both as a genuine desire to safeguard others and as an attempt to find some way of coping with their own pain or loss.[33] Another form of accountability frequently

[28] In the civil system through an independent expert witness instructed by their solicitor, the patient would gain access to the clinical reports. This would not be available through the complaints procedures. Vincent, Phillips and Young (n 26).
[29] Bismark, Dauer, Paterson, et al (n 25).
[30] Bismark, Spittal et al (n 4), 808. This resonates with research from New Zealand, the UK, the USA and the Netherlands.
[31] G Hickson, E Clayton, P Gitnens, and F Sloan, (1992) 'Factors that Prompted Families to File Medical Malpractice Claims following Perinatal Injuries' 267 *Journal of the American Medical Association* 16, 1359–63.
[32] Vincent, Phillips and Young (n 26). See additional bibliography below.
[33] Ibid.

sought was the wish to secure information and greater transparency about what had happened. Such clarification was particularly important in families of infants and children who had been harmed by medical care. This was the only subgroup of patients for whom a desire for communication was mentioned more frequently than a desire for correction.[34] Other wishes for redress included apologies and assurances that someone accepted responsibility. Patients who sought non-monetary relief also desired restoration and sanction, but these were less prevalent issues. A growing emphasis on the need to disclose adverse outcomes of care was noted.[35]

I now turn to the issues around openness: explanation and the taking of responsibility and apology where appropriate. In order for these to constitute effective redress, satisfactory communication is required.

B. Communication: Can You Hear Me?

Although open disclosure is lauded as a 'good' it is a more complicated concept than it first appears. Information is power and initially, in clinical negligence cases, information resides with the defendants. I would place the need for explanation as the first priority for iatrogenically harmed patients because there is a 'need to know' before any coming to terms with or grieving for a loss can occur.[36] As Beverly Raphael explains:[37]

> Sudden, unexpected and unanticipated deaths, especially deaths of the young, that are perceived as untimely, are more likely to be associated with pathological outcomes…Often much psychic energy goes into trying to make meaning of the death, *finding out why it happened, who is to blame, perhaps because the bereaved hopes to prevent such shock in the future or to undo what has happened*. This may be further complicated by a failure to see the body of the dead, adding to the problem of accepting the finality of the loss.[38]

[34] Ibid.
[35] Bismark, Dauer, Paterson, et al (n 25).
[36] CM Parkes, *Bereavement: Studies of Grief in Adult Life*, 4th edn. (Harmondsworth, Penguin, 2010). The recent Hillsborough report (see page 59 herein, n 86) also highlighted the need for people to have correct information before they can come to terms.
[37] Beverley Raphael, *The Anatomy of Bereavement: Handbook for the Caring Professions* (London, Routledge, 1985), 222–223.
[38] Ibid. Italics mine.

There is the complex issue of the content of what is to be disclosed;[39] the receptiveness of the hearer and the ability and willingness of the physicians to tell. These are some of the features which inhibit successful communication even when there is good faith on both sides. It is noteworthy that these conversations often take place in an emotionally charged situation.

1. The Patient's Perspective

In a thoughtful study[40] it was found that the desire for information, perception of being misled, anger with the medical profession, desire to prevent injuries to others, recognition of long term sequelae and advice from knowledgeable acquaintances, as well as the need for money, appeared to contribute to families' decisions to file malpractice claims. Patients identified two general types of communication problems. They believed that some physicians had misled them and that others would simply not listen or answer their questions. Some families who believe they were misled may have come to that conclusion when what they remembered hearing about their children's prognosis differed from actual outcomes.[41]

The sources of such discrepancies vary. Families may be correct when they complain that their providers did not tell them the full story. Few physicians are eager to share bad news. Physicians may feel that they are trying to preserve some hope for the family by withholding the full details of an infant's grim prognosis, while others may fear being sued. The responses of the families also contribute to misunderstandings about expected outcomes. They may not understand medical terminology or may fail to raise their most deep-seated concerns or seek clarification of points about which they are confused, either because they have been acculturated not to ask or because they are intimidated or made anxious by discussions with physicians. Other families may experience denial as a part of grieving; some who are given bad news later deny that they were ever given the information. To point out these sources of misunderstanding is not to say that families somehow 'ought to understand better'. Rather it is to suggest

[39] '…negligent adverse events are a subset of preventable adverse events. In practice, there is likely to be considerable uncertainty as to causality and preventability…such uncertainty complicates the disclosure decision. Premature disclosure may cause unnecessary distress, but waiting for an investigation to be completed may increase patient anger and frustration, especially when causality is obscure to the patient and family.' Mazor, Simon and Gurwitz, (n 1).
[40] Hickson, Clayton et al (n 31).
[41] Ibid.

that physicians should be aware that some families have trouble understanding or remembering what they hear so that an attempt can be made to overcome these barriers to communication.[42]

2. The Physician's Perspective

Physicians' difficulties in sharing information and families' problems in hearing what has been said may also have contributed to the perception of some families that they could not find out what happened. Several studies suggest that physicians and patients have different ideas about the amount and type of information that can and should be transmitted; physicians also struggle with what to do in the face of requests for unattainable information and much hinges on the prior and current relationship between the physician and the patient.[43] Working under a threat of litigation creates a climate of fear, which cannot be conducive to the best use of human resources within the medical system.[44] The toll that the blame and fault-based litigation system takes on doctors is high and counter-productive.[45]

3. Government Initiatives

I now turn to the question of the need for there to be open disclosure of adverse events. This relates to the issue of apologies which will be discussed fully in a later chapter.[46] In brief, a 'protected apology' is one where even a full admission of fault cannot be used as evidence against the doctor in a subsequent malpractice action. In recent years in the United States, six States[47] have enacted laws excluding expressions of sympathy after accidents as proof of liability. Such laws however do not remove all barriers to disclosure of medical errors. The law excludes from evidence statements made to the

[42] Ibid.
[43] Ibid.
[44] See Merry and McCall Smith (n 13) at 217; Mulcahy (n 19) and J R Cohen, (2004) 'Toward Candor after Medical Error: the First Apology Law' 5 *Harvard Health Policy Review* 21–24.
[45] For a moving account of the toll on doctors see AW Wu, 'Medical Error: The Second Victim: The Doctor Who Makes the Mistake Needs Help Too' (2000) 320 (7237) *British Medical Journal,* 726−727. See also Chapter 7 'History of the Complaints Process – a 'Curate's Egg?' below for initiatives in training doctors to deal with adverse events.
[46] Ibid.
[47] See Cohen (n 44) for an example of a legal initiative in Colorado, USA. Ibid. Also for the laws of the six states referred to: Mass Gen Laws Ann ch 233, 23D; Tex Civ Prac and Rem Code Ann 18.061; Cal Evid Code 1160; Fla Stat 90.4026; Rev Code Was 5.66.010; Tenn Evid Rule 409.1.

patient, but not statements made, for example, to one's colleagues.[48] While the case for open disclosure to patients is strong from the viewpoint of medical ethics, the reality in practice is different.[49] Yet it is precisely failure to admit a mistake and apologise for it that can prompt a lawsuit.[50]

There are three important aspects to highlight. The first is in regard to the right to information. If the medical provider does not offer that information, some patients or their families will sue to get it.[51] Second is the issue of betrayed trust. To be effective, the physician-patient relationship must be rooted in trust. And finally, there is the matter of dignity. Failure to apologise after injury can itself be a form of injury.[52] By removing the spectre of liability from the physician-patient dialogue, a law creating an apology exception can help maintain the physician-patient relationship after an error occurs. Even with protected apologies, however, compensation may still be required. In particular, where medical errors have been severe, the critical issue is not whether an apology will prevent all legal recourse, but rather how it will influence the character of that recourse. The hope is that compensation will then be achieved by a relatively cooperative and speedy settlement process rather than more lengthy, costly and unpredictable litigation.[53]

One caveat must be included. Although ethical and professional guidelines, with public support, recommend disclosure of medical errors to patients, there has been insufficient empirical evidence to support conclusions about the disclosure process or its consequences. Additional research is needed to understand how disclosure decisions are made, to provide guidance to physicians on the process and to help all involved anticipate the consequences of disclosure.[54]

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[48] Ibid.
[49] Ibid.
[50] Ibid.
[51] Ibid, footnote 14 therein. S Gilbert, *Wrongful Death: A Medical Tragedy* (New York, WW Norton & Co., 1997).
[52] Ibid.
[53] Ibid, footnote 26 therein. DN Frenkel and CB Liebman, 'Words that Heal' (2004) 140 *Annals of Internal Medicine* 6, 482–3.
[54] Mazor, Simon and Gurwitz, (n 1).

III. OPEN DISCLOSURE: GOVERNMENT INITIATIVES DISCLOSURE TO PATIENTS

In *Making Amends,*[55] Sir Liam Donaldson, the Chief Medical Officer, discussed the aims of redress in his proposals to reform clinical negligence in the NHS. In the context of the need for open disclosure, it was to be hoped that the 'risks of care are reduced and patient safety improved because medical errors and near misses are readily reported, successfully analysed and effective corrective action takes place and is sustained.'[56] A number of initiatives ensued, briefly mentioned herewith. However, as Emma Cave says, 'evidence suggests that defensiveness amongst the medical profession remains a persistent problem, though the associated costs are difficult to quantify.'[57] A duty of candour was called for by the Chief Medical Officer (hereinafter 'CMO') in *Making Amends*[58] and, in 2009, the House of Commons called for such a duty to be reconsidered.[59] As Emma Cave observes,

> The Department of Health has responded cautiously and disjointedly. It promised a culture of openness in *High Quality Care for All.*[60] Section 2 of the Compensation Act 2006 reassured healthcare professionals that: 'An apology, offer of treatment or other redress shall not of itself amount to an admission of negligence or breach of statutory duty'. According to the National Patient Safety Agency,[61] '[s]aying sorry is not an admission of liability and is the right thing to do... Patients have a right to expect openness in their healthcare'.[62] This is a stance enforced by the Care Quality Commission (hereinafter 'CQC'),[63] the NHS Litigation Authority (hereinafter 'NHSLA'),[64] and the General Medical Council (hereinafter 'GMC').[65] In April 2010, a statutory duty to report incidents was introduced.[66] The NPSA will pass on details of incidents to the CQC which can impose fines and registration penalties if the guidelines are not strictly

[55] Chief Medical Officer *Making Amends: A Consultation Paper Setting out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (Crown Copyright, Department of Health, 2003) hereafter CMO *Making Amends.*
[56] Ibid, 13.
[57] E Cave, 'Redress in the NHS' (2011) 27 *Professional Negligence* 3, 138–157 offers a comprehensive summary of initiatives towards redress and open disclosure at 145.
[58] CMO *Making Amends* (n 55) at 18 and 125.
[59] Cave (n 57), footnote 56 therein: House of Commons *Health Committee Sixth Report* (2009), para 91.
[60] Department of Health, *High Quality Care for All* Cm 7432 (2008), ch 5, paras 21-25.
[61] hereafter NPSA.
[62] NPSA, *Being Open: Communicating Safety Incidents with patients, Their Families and Carers* NPSA/2009/PSA003, (London: DH, 2009), 6.
[63] Care Quality Commission, *A Quality Service, A Quality Experience* (London: CQC, 2009).
[64] National Health Service Litigation Authority, *Apologies and Explanations: Letter to Chief Executives and Finance Directors* (London, 2009); See J Wright, G Opperman, 'The Disclosure of Medical Errors: A Catalyst for Litigation or the Way Forward for Better Patient Management?' (2008) 14 *Clinical Risk* 193.
[65] GMC, *Good Medical Practice* (London, GMC, 2006), para 30.
[66] Care Quality Commission (Registration) Regulations 2009, SI 2009/3112, Regulation 18.

> followed.[67] A more comprehensive approach was promised in the Department of Health's White Paper *Liberating the NHS*, where the Government undertook 'to require hospitals to be open about mistakes and always tell patients if something went wrong'.[68,69]

There is, however, no need to restrict the duty to hospitals. Primary carers could also be required to be candid. Early day motions in 2010[70] proposed that the duty be put on a statutory footing but ministers are still prevaricating about whether such a duty will be brought in.[71]

I concur with Emma Cave[72] who concludes that *requiring* openness is only part of the solution. It is also necessary to create an environment whereby doctors are willing to admit their errors or mistakes and to report those of others,[73] while maintaining individual and institutional sanctions by which they can be held to account.[74] The current clinical negligence system acts as a disincentive to openness.[75] The CMO recommended that a statutory duty of candour be accompanied by an exemption from disciplinary action, where no crime had been committed and it remains safe for the doctor to practise.[76] In addition, documents identifying adverse events would be protected from disclosure in court, as is the case in parts of Canada, Australia and the United States.[77] This does not seem to form part of the Government's plans, yet without

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[67] The Care Quality Commission regulations introduce a statutory duty for healthcare providers to report iatrogenic adverse events to the NPSA but the Government excluded any duty to inform the injured patient or their next of kin. See AvMA Campaign www.avma.org.uk/pages/legal_duty_of_candour_- robbies_law.html 21/10/2010. Updated January 2011.

[68] White Paper *Equity and Excellence: Liberating the NHS* Cm 7881 (2010), 3. For critique, see V Shekar, M Singh, K Shekar and P Brennan, 'Clinical Negligence and Duty of Candour' (2010) 49 *British Journal of Oral and Maxillofacial Surgery* 8, 593-596.

[69] Entire passage quoted from Cave (n 57), 145; fns 61 and 67 are mine; fn 68 has been updated by me.

[70] T Brake, *Campaign for Statutory Duty of Candour in Healthcare* EDM 1163, 23 March 2010; T Brake *Duty of Candour in Healthcare* EDM 486, 13 July 2010.

[71] See AvMA Campaign (n 67).

[72] Cave (n 57) at 146. Emphasis added by Cave.

[73] The Public Interest Disclosure Act 1998 protects workers who 'blow the whistle' about wrongdoing.

[74] For an alternative system see P Vines, 'Apologies and Civil Liability in England, Wales and Scotland: The View from Elsewhere' (2008) 12 *Edinburgh Law Review* 2, 200.

[75]The Final Report of the Bristol Royal Infirmary Inquiry began as a public inquiry into the abnormally high death rate for paediatric heart surgery at Bristol Royal Infirmary, but it culminated in some damning conclusions about the NHS's response to adverse events and argued that clinical negligence should be abolished. It found that clinical negligence litigation did not represent a systemic approach to accountability or proper analysis of error. The view was ultimately taken that it would not be possible to achieve an environment of open reporting within the NHS when, outside it there exists a litigation system the incentives of which press in the opposite direction. The way forward must be a new approach to compensating those patients harmed through adverse events.

[76] CMO *Making Amends* (n 55) at 18 and recommendation 12 at 125.

[77] Ibid, recommendation 13 at 126.

it, the incentive for openness and honesty remains limited.[78] I agree with Cave that despite aspirational publications, Government initiatives have delivered neither a statutory duty of candour[79] nor an appropriate legal context for encouraging significant apologies.[80] However, I would argue that even if everything were in place, there is an inherent mismatch between patients' desires and expectations in these difficult circumstances and what any explanation and apology can assuage.[81] I also emphasise the communication disconnect discussed above which also is a limiting factor. Nevertheless, at the very least, patients and their families are owed honest explanations of iatrogenic adverse events.

[78] Cave (n 57) at 146.
[79] See AvMA Campaign (n 67) emphasising the need for a statutory duty of candour in healthcare.
[80] Vines (n 74). This approach will be discussed in Part III Redress within the NHS below.
[81] Bismark, Spittal et al (n 4) at 806 discusses the 'expectations gap' discordance between what patients want and what they get from the New Zealand complaints commission.

IV. WHAT PATIENTS SEEK FROM REDRESS: CONCLUSIONS

This chapter began by addressing four aspects of redress for iatrogenically injured patients, namely: restoration, correction, communication and sanction.[82] The question of providing redress for such victims was examined within the context of corrective justice principles. These supply the moral imperative for the tortfeasor to compensate the victim even when the harm was unintentionally occasioned. Both because the financial aspect of redress made a call on the scarce resources of a universal health service and thereby engaged distributive justice principles,[83] and because non-pecuniary loss is by its very nature uncommodifiable, I have argued that outside of compensation for pecuniary loss, more imaginative methods of redress were called for. I have discussed the desire of patients for restoration, in Marie Bismark's terms[84] money. It was clear from the literature that although financial compensation was a necessity and desire from some patients, usually the wish for damages was accompanied by the need for explanation, communication, correction and sanction. I have also discussed the subtle and nuanced communication difficulties between patients and physicians which provide a barrier to resolution.[85]

In their earlier paper Bismark[86] et al were hopeful that the New Zealand no-fault system would offer patients more satisfaction than the traditional adversarial approach of the Anglo-American system. However, in a more recent paper,[87] dissatisfaction with the redress process was particularly notable. This dissatisfaction flowed from a 'gap between demand and response.'[88] The authors offer two solutions for narrowing the gap. One is to correct expectations with 'reality mediation'. The other is to design the systems to offer more of what complainants seek. I would argue that satisfaction for

[82] Bismark and Dauer (n 3). This chapter lays the foundation for fuller discussion of redress in the body of the thesis. Part II Medical Negligence Litigation and Part III Redress Within the NHS below.
[83] Regarding distribution of assets.
[84] Bismark and Dauer (n 3).
[85] The issue of professional sanction and discipline will be addressed in Part III 'Redress within the NHS' below.
[86] Ibid.
[87] Bismark, Spittal et al (n 4).
[88] Ibid. The 'expectations gap' discordance between what patients want and what they get from the New Zealand complaints commission.

redress in clinical negligence is always doomed to be partial due to the nature of the loss.[89]

In a reply to this article, Edward Dauer[90] suggests a different formulation of the question with which I concur. 'The question could, however, be approached from a different starting point. What objectives, exactly, should a legal system seek to achieve in the aftermath of an adverse medical event? Is satisfaction with remedial outcomes one of them?' I agree with Dauer that one's aspirations for 'making good' or restoration need to be more limited in order to be realistic. The principal objectives should be three: restoration of the patient to a pre-event condition as nearly as may be; accountability for individual and institutional providers when they err; and learning – using today's adverse outcome to help prevent tomorrow's. Each of these has two components to be measured: the subjective expectations of the patient and the objective measures in the medico-legal system. His main emphasis is on quality and safety, both 'goods' patients wanted. Paradoxically, having more limited but possible aims could lead to greater satisfaction for patients.

The context within which redress for iatrogenic harm operates is the fault-based liability system in operation in England.[91] The current adversarial system fits in with corrective justice principles where the tortfeasor is responsible to his victim. However, it is clear that the system of redress is imperfect, leaving iatrogenically harmed patients at a disadvantage when attempting to establish liability[92] and damage. What patients want is to be made whole again and what physicians want is for the unintended adverse event never to have happened. Given that these are impossible goals, one looks at the art of the possible. I would argue that the aim of redress in these circumstances should not be measured by the amount of litigation which does or does not ensue but by what is a just result. If a patient is iatrogenically harmed he deserves to be given the necessary information to make an informed choice of how to go about seeking redress: financial for pecuniary loss and extralegal measures for non-pecuniary loss. As the redress available is constrained by the limitations of the budget of a universal healthcare system, I would still not offer damages for non-pecuniary loss. The most glaring

[89] See discussion in last paragraph of previous section.
[90] Dauer (n 2).
[91] Discussion of a no-fault system is outwith the remit of the thesis but see E Jackson, *Medical Law* (Oxford University Press, 2nd edn, 2010), 161.
[92] See Part II Medical Negligence Litigation below.

vacuum in the redress landscape remains the fact that the complaints and claims systems operate independently.[93]

I now turn to the second part of the thesis concentrating on medical negligence litigation, funding litigation, proving liability and damages as redress. This will be followed by the third part of the thesis, analysing extant and future redress within the NHS.

[93] See Chapter 8 'The NHS Redress Act 2006 – a Lost Opportunity?'

PART II

MEDICAL NEGLIGENCE LITIGATION

CHAPTER 3

FUNDING LITIGATION

Blind Plaintiff, lame Defendant, share
The friendly Laws impartial care,
A Shell for him, a Shell for thee
The Middle is the Lawyer's Fee

Benjamin Franklin, Poor Richard's *Almanac, 1733, in Papers of Benjamin Franklin 1:318* (Leonard W Labaree ed 1959)

I. INTRODUCTION

This part of the thesis addresses the legal route to justice.[1] In this chapter, I will consider whether the arrangements, both extant and projected, for funding clinical negligence actions assist or adversely affect access to justice. At present,[2] clinical negligence actions may be funded by legal aid; conditional fee agreements (hereinafter 'CFAs'); private claimant funding; third-party funding; speculative fee agreement; pro bono; contingency fee arrangements; before the event insurance; after the event (hereinafter 'ATE') insurance; own legal costs and opponents' legal costs; litigation funding agreement and contingent legal aid fund (hereinafter 'CLAF').[3] For present purposes, I will be focusing on funding through legal aid, conditional fee ('no win, no fee') agreements, insurance and the issue of costs. Nevertheless, it is clear that reform of legal aid is on the Government's agenda with the publication of consultation documents: *Proposals for the Reform of Legal Aid in England and Wales*[4] and *Proposals for Reform of Civil Litigation Funding and Costs in England and Wales: Implementation of Lord Justice Jackson's Recommendations*.[5] It is proposed that 'all clinical negligence cases be excluded from civil legal aid because there is a viable alternative source of funding in CFAs'.[6] However, recognising that some individual cases will continue to require public funding even once they are removed from scope, it is proposed that a power to grant legal aid in certain circumstances be retained.[7] I will consider the Government's rationale and justification for the use of legal aid and the cases meriting exception. At the conclusion of the chapter I will briefly present arguments challenging the assumption that access to justice would not be adversely affected by this change. Access to justice has two aspects: the availability of legal representation in the civil justice system; and access to redress through extralegal routes such as the NHS complaints

[1] The subsequent Part III will address Redress within the NHS.
[2] January 2011.
[3] M Powers, N Harris and A Barton, *Clinical Negligence* 4th edn (Haywards Heath, Tottel Publishing, 2008) ch 11 'Funding Clinical Negligence Claims' at 249.
[4] *Proposals for the Reform of Legal Aid in England and Wales* www.justice.gov.uk/consultations/legal-aid-reform-151110.htm at 4.8. Any changes to legal aid are unlikely to be implemented before 2012.
[5] *Proposals for Reform of Civil Litigation Funding and Costs in England and Wales: Implementation of Lord Justice Jackson's Recommendations*, http://www.justice.gov.uk/consultations/Jackson-review-151110.htm.
[6] *Proposals*... (n 4) at 4.166.
[7] Ibid at 1.11.

system. The challenge of widening access to justice is to address both these aspects in a way that is financially viable.[8]

A. Clinical Negligence: A Special Case?

Clinical negligence actions are a category of personal injury claims. Most claims in respect of medical injury are brought in tort, that is, on the basis of a non-contractual civil wrong. Due to the complexity and unpredictability of these claims, which can require *inter alia* high disbursement costs, funding arrangements differ from the general personal injury claims[9] and presently legal aid remains available for clinical negligence litigation.

The imperative necessity of 'access to justice' in clinical negligence cases may be found in the judgment of Hale LJ in *Parkinson v St James NHS Trust* (CA):[10]

> The right to bodily integrity is the first and most important of the interests protected by the law of tort, listed in *Clerk & Lindsell on Torts,* 18th edn (2000) paragraphs 1–25. 'The fundamental principle, plain and incontestable, is that every person's body is inviolate' see *Collins v Wilcock* [1984] 1 WLR 1172, 1177. Included within that right are two others. One is the right to physical autonomy to make one's own choices about what will happen to one's own body. Another is the right not to be subjected to bodily injury or harm. These interests are regarded as so important that redress is given against both intentional and negligent interference with them.

In Lord Woolf's Final Report on *Access to Justice*,[11] medical negligence (clinical negligence) claims were singled out for special consideration because the 'civil justice system was failing most conspicuously to meet the needs of litigants in a number of respects'. These included the disproportion between costs and damages in these cases,[12] the unacceptable delay in resolving claims and the lower success rate than in other personal injury litigation. Lord Woolf expressed concern that 'in the vast majority of clinical negligence cases both sides were funded from the public

[8] Powers et al, n3, Introduction at 249.
[9] Nevertheless requirements to show duty, breach and causation remain the same.
[10] *Parkinson v St James NHS Trust* (CA) [2002] QB paras 56–57. This was suggested by Allan Gore QC, President of the Association of Personal Injury Lawyers at a Journal of Personal Injury Law Conference on 4 November 2005.
[11] H Woolf, *Access to Justice: Final Report to the Lord Chancellor on the Civil Justice System in England and Wales*, (London, Lord Chancellor's Department, 1996). online at: http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/civil/final/index.htm.
[12] 'The principle of proportionality'.

purse and the amount of money spent by NHS Trusts and other defendants on legal costs was money which would be much better devoted to compensating victims, or better still, to improving standards of care so that future mistakes are avoided.'

Lord Woolf's concern was paralleled by Sir Ian Kennedy in the Bristol Royal Infirmary Inquiry[13]:

> The crucial difference, apart from any structural differences between the law and practice in England as compared with the various states in the USA, may lie in the source of the funds for compensation. In the USA, the hospital claims from its insurer, which passes on the cost in increased premiums for healthcare insurance, which the hospitals in turn pass on to the patients in increased healthcare costs. In the UK, it is the service provider, the NHS, which pays the cost and, short of increasing taxes, or taking the funds from elsewhere in the public sector, money spent on meeting claims is money not spent on care.

It is precisely because clinical negligence claims are funded from the NHS budget that the problem becomes acute.

The Government recognised the inherent difficulties of funding clinical negligence litigation by CFAs and retained legal aid for these cases after it was withdrawn from other personal injury work in April 2000. At present, for clinical negligence claims there is still the possibility of public funding through legal aid if certain conditions are met. If found ineligible for legal aid, a claimant may proceed on a CFA with his lawyers, or a last recourse would be private funding, but this could prove prohibitively expensive. However, if the Government's changes to the legal aid system are accepted in their current form,[14] claimants will need to rely on before the event insurance or on claimants' solicitors offering them CFAs to be able to fund a claim. Nonetheless, as noted, within the details of the Government's proposals there may be a reprieve for some claimants.[15]

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[13] *The Bristol Royal Infirmary Inquiry* led by Sir Ian Kennedy, July 2001, ch 26, p 370, para 45, s 2.

[14] The Legal Aid, Sentencing and Punishment of Offenders Act 2010–12 incorporating Lord Justice Jackson's reforms received Royal Assent on 1 May 2012.

[15] Ibid. 'Some cases will continue to require public funding…and there is a proposal retaining a power to grant legal aid in some circumstances.' Section 6(8) of the Access to Justice Act 1999 empowers the Lord Chancellor to issue instructions to bring certain services back into scope either on a general basis or in respect of an individual, notwithstanding their inclusion in schedule 2 which removes certain matters from scope. See Introduction and Chapter 4.

B. Funding Legal Actions

The underlying question behind this discussion of funding clinical negligence claims is whether the system in place and projected impedes or aids access to justice through the legal route to redress. In the introduction to the consultation document,[16] the Government maintains its commitment to access to justice as 'a hallmark of a civilised society' and its aim to ensure that legal aid is targeted to those who need it the most. Nevertheless, the Government is explicit that against a background of considerable financial pressure on the legal aid fund, the proposals have been developed with the aim of delivering savings of £350 million in 2014–15 on legal aid by the final year of the spending review period.[17] After briefly considering the legal aid scheme in its historical context, I will be focusing on the issues inherent in funding litigation through legal aid. The final form of Government funding is still open for consultation, as Sir Rupert Jackson has proposed to introduce a supplementary legal aid scheme and this is also under consideration.[18]

II. LEGAL AID

A. Legal Aid in the Past: Whither the Welfare State?

According to Michael Zander QC 'the phrase "Access to Justice" has become a term of art signifying the arrangements made by the state to ensure that the public at large, especially those who are indigent, can obtain the benefits available through the use of the law and the legal system.'[19] The legal aid system was principally established by the Attlee government by means of the Legal Aid Act 1949 which gave an entry to justice for citizens. This Act, setting up the civil legal aid scheme, was an historic stage in the story of legal services for the poor. The legal aid scheme enabled a person to have all or part of the costs connected with legal proceedings (including solicitors' and barristers' fees) paid from public funds. For legal advice and assistance, other than proceedings, a separate arrangement, known as the 'green-form scheme' was available.[20] If a citizen

[16] *Proposals...* (n 4), ch 2 at 2.2.
[17] Ibid ch 2 at 2.3.
[18] Ibid ch 4 at 4.167–9.
[19] M Zander, *The State of Justice*, The Hamlyn Lectures Fifty First Series, (Andover, Sweet & Maxwell Ltd., 2000). See below for current criteria for accessing legal aid in clinical negligence cases.
[20] The green form scheme covers advice before a case goes to court.

with a legal problem could establish that he qualified for legal aid under the means test and the merits test, he had an entitlement to legal aid.[21] Fifty years later, the Access to Justice Act 1999 (hereinafter 'AJA' 1999) restricted this entry. The 'New Jerusalem' envisaged by Beveridge and enacted by Aneurin Bevan had simply become too expensive to maintain and all parts, including the legal area, were now subject to restriction.[22]

B. Reform of Civil Procedure

Lord Woolf's reports[23] presented a vision that those who sought to bring cases to court should be able to do so efficiently and at a cost proportionate to the amount in dispute.[24]

The late 1990s saw the Government undertake a fundamental review of both the civil justice system and the means by which legal services could be provided and financed. The Lord Chancellor's Department issued a consultation paper entitled *Access to Justice with Conditional Fees: A Consultation Paper*, in March 1998.[25] The rationale of criticism of the legal aid system was:

> The present civil justice system falls woefully short of the ideal that there should be justice for all of us when we need it. The system is too complex, takes too long to deal with cases and is too costly. The number of people entitled to legal aid has gone down. A huge swathe of ordinary people on modest incomes are deterred from starting a legal action by the potential costs of litigation – their own costs and the risk of ending up paying the costs of the other side...The current system does not encourage lawyers...to weed out weak cases...at the same time the cost of the Legal Aid Fund goes up and up. Net expenditure in 1990–91 was £682 million. Only six years later, expenditure had more than doubled to £1,477 million. This is an increase of 115%...

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[21] To determine whether an applicant is financially eligible for legal aid, the Legal Aid Office will undertake a means test to determine whether the applicant's finances are within the required limits for legal aid under the Legal Aid (Financial Resources) Regulations 1997. The merits test enquires whether or not the proceedings have legal merit. This point will be dealt with between the Advocate and the Legal Aid Certifying Officer. See below for questions of evaluation of success rates now required for access to legal aid.

[22] C Barnett, *The Lost Victory, British Dreams, British Realities 1945–1950*, (London, Pan Books, 1995, Reprint 2001). For historical background see the Department of Constitutional Affairs 'A Fairer Deal for Legal Aid' Cm 6591 (July 2005) signed by Charley Falconer, Lord Falconer of Thornton, Secretary of State for Constitutional Affairs and Lord Chancellor.

[23] There were two reports, both entitled *Access to Justice*. The Interim Report was published in 1995; the Final Report in 1996. Both were published directly by the Lord Chancellor's Department.

[24] For details of the proposals see M Partington 'Access to Justice: Reforming the Civil Justice System of England and Wales' (2001) 30 *Common Law World Review* 115. Proposals include changes to Civil Procedure Rules (1999) and support for Alternative Dispute Resolutions.

[25] Lord Chancellor's Department: *Access to Justice with Conditional Fees: A Consultation Paper*, (London, Lord Chancellor's Department, March 1998).

> When Legal Aid was set up 50 years ago, it was a great step forward. It brought the opportunity of access to justice within the reach of the majority of the population. Now it is failing the very people it was supposed to help...[26]

Subsequently, there have been a number of changes to the operation of the legal aid schemes, in particular, the 1999 Access to Justice Act which *inter alia* established the Legal Services Commission (hereinafter 'LSC') to administer the schemes. The 1999 Act also introduced limitations on the scope of legal aid, removing most personal injury cases. The LSC was empowered to set standards for service provision so that legal aid services could only be supplied by franchised legal firms. Additionally, the Funding Code,[27] which introduced a more stringent merits test for civil and family cases, was established.[28] Since 2006, there have been over 30 separate consultation exercises on legal aid and, as noted, at present the Government has undertaken a new review of legal aid in England and Wales wherein it is proposed to exclude legal aid from civil legal aid funding.[29] The Government's hypothesis is that CFAs will provide a viable alternative source of funding for these actions. I will address this issue in the conclusion of the chapter following discussion of CFAs.

C. The Legal Aid System: Effect on Litigation

An interesting consequence of litigation when legal aid funds an action was noted in the Law Society Research Study No 38, concerned with 'Access to Legal Services.'[30] The study showed that 'the way in which a personal injury case is funded has a major impact on the way that it is pursued'. Effects on the litigants were outlined thus:

> A salient feature of the legal aid system was that legal aid protected victims from the fear of costs should the case proceed to court. This report remarked that: 'this isolates claimants from some of the pressure to settle and allows them to pursue the case for longer.

[26] Ibid.
[27] http://www.legalservices.gov.uk/civil/guidance/funding_code.asp.
[28] For further details of historical changes see *Proposals…* (n 4), ch 3 Background.
[29] Ibid Ministerial Foreword.
[30] T Goriely and A Paterson, *Access to Legal Services: A European Comparison A Review of the Literature Research Study No. 38* (London, The Law Society Research and Policy Planning Unit, 2000), 35.

Additionally, it has been found that, where the plaintiff was legally aided, personal injury cases took longer and cost more. Defendant insurance companies were more likely to offer larger settlements if they knew the victim could go to court and that the insurer would not be awarded its costs if it won. [31]

D. Modern Times: Legal Aid in Action at Present

1. The Legal Framework for Funding Legal Aid

The AJA 1999, which came into effect in 2000, abolished the legal aid scheme and introduced in its place a new body – the LSC charged with running two new services: the Community Legal Service (hereinafter 'CLS') and the Criminal Defence Service (hereinafter 'CDS').[32] When considering the possibility of legal aid being removed from clinical negligence actions, it is important to note that this sphere of governmental activity is subject to the scrutiny of the Administrative Court. Decisions of the LSC and those of the Funding Review Committee (hereinafter 'FRC') have been challenged by way of judicial review. After a short description of the legal framework within which legal aid operates, I will consider past challenges to funding decisions before the Administrative Court.[33]

a) The Legal Framework: Access to Justice Act 1999

Section 4(2) of the AJA sets out in general terms the types of services which the LSC may fund. This power is qualified by section 6, which removes certain matters from scope, listing these in schedule 2, and which also empowers the LSC to prioritise and hence decide upon services it wishes to fund. Section 6(8) empowers the Lord Chancellor to issue directions so as to bring certain services back into scope either on a general basis or in respect of an individual, notwithstanding their removal from the scope under schedule 2.

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[31] H Genn, *Survey of Litigation Costs: Research conducted for Lord Woolf's Inquiry into Access to Justice* (London, Lord Chancellor's Department, 1996).
[32] Partington (n 24). The latter will not be considered here. For more detail on CLS than will be provided here see the full article.
[33] C Haley, 'Civil Legal Aid – The Challenges' (2004), published online by the Legal Action Group, The Public Law Project at http://www.publiclawproject.org.uk/downloads/CivilLegalAid.pdf

Section 8 requires the LSC to prepare a Code setting out (1) the general criteria it is to apply to individuals seeking funding and (2) the procedures it will use to determine such applications. The Code on procedures provides that the LSC decision makers should have regard to guidance issued by the Lord Chancellor (under section 23 of the Act) and to that issued by the LSC itself and also contains the rights of appeal to the FRC.

Funding for the Community Legal Service is provided by Government and distributed by the Commission under the terms of a Funding Code which sets out the detailed framework within which legal services will be delivered. The Funding Code offers two levels of service to be funded by the CLS for clinical negligence cases. Legal Help – advice and assistance; and Legal Representation which is licensed work only to be undertaken by franchised firms. Legal Representation can be Investigative Help – available when a case needs substantial investigation before its prospects of success can be determined; and Full Representation available only for strong cases. The General Funding Code sets out the criteria for clinical negligence cases.[34]

Whereas the old legal aid system was 'demand-led' so that any case which could fulfil the merits test for a client who was financially eligible would be funded, the intention of the new regime was to introduce stricter budgetary controls. In theory at least, 'affordability' is now a key feature. The merits test has also been refined, replacing the old 'private client' test with stricter imposition of cost/benefit criteria. Costs payable by the LSC have been strictly curtailed. Solicitors able to act for legally-aided clients must be approved by the LSC and only firms who hold such a franchise can act.[35]

Briefly, only services for individuals may be funded under the scheme. In addition, certain types of legal service are excluded from the scheme altogether, which includes personal injury cases but not clinical negligence cases. The broad exclusion of funding services for representation before coroners' courts and tribunals is retained.[36] However, as noted, the Lord Chancellor has discretion to fund exceptional cases before tribunals or the coroner's court where strict criteria are met (bringing an exception back into

[34] See CJ Lewis, *Clinical Negligence*, 6th edn (Haywards Heath, Tottel, 2006) 36 for details of funding code.
[35] P Balen, *Clinical Negligence* (Bristol, Jordan Publishing Limited, 2008) 64.
[36] See *R (On the application of Mohammed Farooq Khan v Secretary of State for Health)* [2003] EWCA Civ 1129. In complex cases Article 2 requires that the family of the deceased have legal representation at the inquest. Also see Part III Redress within the NHS below; section on inquests and coroner's court and legal representation.

scope).[37] As alternative funding sources develop, such as conditional fee arrangements and legal expenses insurance,[38] then categories of work publicly funded may be removed from the scope of the CLS. In addition, where the proceedings are designed to obtain an award of damages or other financial provision, any award of damages is subject to a 'charge' in favour of the CLS Fund.

Thus, account must be taken of whether proceedings would be cost-effective.[39] There must be an assessment of the prospects of success.[40] Cost-benefit ratios are to be determined by relating the likely costs to the percentage prospect of success.[41] Funding will be refused in cases where a CFA should be obtained. Special arrangements continue to apply to multiparty actions, where a large number of claimants are claiming loss from a single event or cause.

E. The Future: Proposals for the Reform of Legal Aid

The changes proposed by Kenneth Clarke's review of the legal aid system[42] have been presaged in the AJA 1999 whose purpose was to target the limited resource of legal aid so as to widen access to justice. The underlying policy of the 1999 Act was to widen access to justice and to promote the replacement of civil legal aid by the conditional fee system.[43] The Government's current position[44] is that the legal aid scheme in its current form is no longer sustainable financially and difficult decisions need to be made about where to target scarce resources. The factors to be taken into account to justify legal aid are: the importance of the issue; the litigant's ability to present their own case (including the venue before which the case is heard); the likely vulnerability of the litigant and the complexity of the law; the availability of alternative sources of funding; and the

[37] Section 6(8) AJA 1999.
[38] Discussed below. These sources are also important in funding clinical negligence cases which do not meet the strict means and merits criteria of the CLS.
[39] In framing the Funding Code's provisions on these matters, the Legal Services Commission is required to take into account the statutory factors, which are set out in s. 8(2) of the Act.
[40] This criterion will not apply in cases with a wider public interest. The Legal Services Commission will be advised on the public interest by a Public Interest Advisory Panel 2.
[41] For example, where the prospects of success are 80% or better, the likely damages must exceed the likely costs; where the prospects of success are 60–80%, the likely damages must exceed likely costs by 2:1 and where prospects of success are between 50–60%, the likely damages must exceed likely costs by 4:1.2.
[42] *Proposals* ... (n 4).
[43] Powers et al (n 3).
[44] *Proposals*... (n 4), at 4.12.

availability of alternative routes to resolving the issue. Account is also taken of the Government's domestic, European and international legal obligations.[45]

F. The Claimant's Rights: Challenges to Refusals of Legal Aid

1. Challenges to Funding Decisions Before the Administrative Court

Institutions which provide publicly funded services may be subject to liability through the mechanisms of public law by means of judicial review of administrative action. A successful challenge in judicial review normally does not give rise to an award of damages and the judgment of the court merely obliges the institution to retake its decision in accordance with the law as articulated.[46] In the *Proposals for the Reform of Legal Aid*[47] it is acknowledged that 'proceedings where the litigant seeks to hold the state to account by judicial review are important because they are the means by which the citizen can seek to ensure that state power is exercised responsibly'. The issues at stake in public law challenges are deemed to be of high importance and, where alternative forms of dispute resolution, such as complaints procedures or referral to an ombudsman, have not succeeded, legal aid will remain available for public law challenges.[48] It is proposed that claims against public authorities should continue to receive legal aid where they concern abuse of position of power; and/or significant breach of human rights; and/or negligent acts or omissions falling very far below the required standard of care.[49] I will now consider the court's general approach to several challenges of refusals of legal aid.

a) Multiparty Actions

The rules of the Supreme Court and the legal aid system were essentially designed to deal with individual cases. Because defective medical products and devices can cause injury on a large scale, they are liable to generate multiparty actions. These cases can pose intractable problems of procedure and case management and can involve

[45] Ibid ch 4 at 4163–169 for full details.
[46] I Kennedy, A Grubb, J Laing and J McHale, *Principles of Medical Law,* 3rd edn (Oxford, OUP, 2010) at 417 and see their footnote 152.
[47] *Proposals…* (n 4), ch 4 at 4.96
[48] Ibid.
[49] Ibid at ch 4.52.

protracted and costly hearings and the imbalance in financial resources and expertise between multinational corporations and claimants continues to pose formidable problems in funding large-scale group actions.[50] In *W (R on the application of) v Legal Services Commission*[51] the MMR (Measles Mumps and Rubella) vaccine case, the Applicants' funding from the LSC had been withdrawn and the decision upheld by the FRC, Davies J opined that the decision of the FRC was proportionate, rational and took into account the relevant considerations; it was sufficiently reasoned and there had been no procedural unfairness. We see then that in any claim for judicial review, the Administrative Court considers the actions of the LSC and FRC against the benchmark of common law principles. However, this decision is one of a number where the LSC has refused to fund certain group actions (such as that brought by the survivors and families of the Potter's Bar rail crash) and there have been calls for a different approach to be taken by the LSC in such cases. One such approach would be to give greater weight to public interest considerations rather than to financial ones.[52] However, the recent decision to withdraw legal aid funding from a case aimed at compensating children born with disabilities after mothers took an anti-epilepsy drug Epilim is an indication that the LSC's thinking about such cases remains constant.[53] The civil procedure reforms, at the turn of the century,[54] introduced the more elaborate mechanism of Group Litigation Orders (hereinafter 'GLOs') which require that claimants need only have 'common or related' issues.[55] The introduction of the GLOs would seem to offer a preferable, more flexible approach. However, claimants may still find it difficult to persuade the court that the cost-benefit ratio justifies the exercise of its discretion to grant a GLO.[56]

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[50] Kennedy et al (n 46) at ch 18: 1007.
[51] *W (R on the application of) v Legal Services Commission* [2004] EWHC 564 (Admin).
[52] See Haley (n 33) for details of further challenges to legal aid refusals. M Day and J Kelleher 'Lessons from MMR and the Future of Group Litigation Funding' (2005) 1 *Journal of Personal Injury Litigation* 98.
[53] 'But the government's LSC, which is believed to have provided more than £3m to help families prepare for the action, decided to end its financial support three weeks before the hearings were due to begin in the high court in London'. The Guardian, 8 November 2010. 'Ministers introduced a £3m cap on all major multiparty cases a year as a result of what the Legal Services Commission has called its "bitter experiences" such as the benzo fiasco… such a limit was a major hurdle when drug companies "will spend tens, if not hundreds, of millions in research and development alone". One of the American lawyers on Vioxx once told me that individual expert reports alone were running into "tens and 20s of thousands of dollars". Epilim joins a dismal roll call: the 2002 oral contraception pill litigation; the MMR litigation; the notorious benzodiazepine tranquilliser cases; and Vioxx.' *The Guardian* 1 February 2011.
[54] *The Civil Procedure (Amendment) Rules* (2000).
[55] As distinct from the 'same interest' required in a representative action.
[56] Kennedy et al (n 46), ch 18 Product Liability, H Teff at 1007.

b) Procedural Challenges

In *Dixon (R on the application of) v Legal Services Commission*[57] public funding was sought for a claim against the claimant's former solicitors in negligence. As a result of disputed Counsel's Advice LSC funding was withdrawn and an FRC hearing provided only a short explanation. A 'reasons point' was then taken against the FRC. The relevance to the present discussion is that the court found that the FRC hearing had provided insufficient explanation for their conclusions. Although the FRC need not provide a judgment to court standards, it is obliged to provide sufficient reasoning of its decisions so as to enable the applicant to understand why his appeal was lost. If no reasons can be offered for a decision, the court may conclude that there had been no good reasons for it and, in turn, that the body has acted irrationally.[58]

In *R (on application of G) v Legal Services Commission*[59] guidance was given as to the relevant criteria to be considered to determine whether a public authority had been culpable of serious wrongdoing by act or omission which justified the public funding of a negligence claim against it. G's application for funding was granted as the Commission had erred in its conclusion that to constitute serious wrongdoing the conduct had to be deliberate, malicious or dishonest. The correct approach should have concerned considerations of the duty of care owed to the family.

We have now seen that decisions to refuse legal aid funding may be challenged in public law on procedural grounds and that the LSC will be expected to give full and transparent reasons for its refusal. The other way the refusals may be challenged is to question whether the manner in which the Lord Chancellor exercises his section 6(8) (b)[60] discretion is compliant with the European Convention of Human Rights (hereinafter 'ECHR'). Claims have been based upon Article 6 and also upon the procedural protection contained in Article 2.

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[57] *Dixon (R on the application of) v Legal Services Commission* [2003] EWHC 325 Admin.
[58] *Padfield v MAFF* [1968] AC 977. See Haley (n 33) for more case law.
[59] *R (on application of G) v Legal Services Commission* [2004] EWHC 276 (Admin).
[60] AJA 1999.

2. The Human Rights Act 1998 and Funding Civil Justice[61]

A significant barrier to access in the English civil justice system is the cost of litigation.[62] Political commitment to the provision of public funding to enable access for all is limited by financial resource constraints and, as we have seen above, the provision of publicly funded legal services is thus subject to qualification.[63]

There is no absolute right to litigate in the civil justice system under the terms of the HRA 1998 Article 6 (1).[64] Under the AJA 1999,[65] the Lord Chancellor is able to authorise the provision of legal aid for those proceedings generally excluded from legal aid provision.[66] The Lord Chancellor, however, has made it clear that approval will be given only in exceptional circumstances. He has indicated that the benchmark will be those cases where the European Court of Human Rights (hereinafter 'ECtHR') has indicated that the right of access to court has been effectively denied due to lack of public funding. The issue as to when the court will find that there has been a violation of Article 6 (1) due to a refusal of legal aid is not straightforward. The final decision as to whether funding will be awarded under the AJA 1999, section 6 (8) (b), rests with the Minister for Legal Aid at the Department of Constitutional Affairs. If such an application reaches the ECtHR on the grounds that the Minister has refused such an application, the court may not approve of the fact that the final decision is made by a Government Minister.[67]

On the whole, human rights challenges of refusals of legal aid in medical cases are not successful.[68] In *Perotti v Collyer-Bristow*[69] the Court of Appeal said the court had no power in civil proceedings to grant a right to representation. The decision whether or

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[61] This discussion relies heavily on S Shipman, 'Case Comment: *Steel & Morris v United Kingdom* Legal Aid in the European Court of Human Rights' (2006) *Civil Justice Quarterly* 25 January, which was a case regarding the European Court of Human Rights decision in *Steel v UK* (68416/01, which held that the failure to provide legal aid to the defendants in the McDonald's Restaurant libel case violated their right to a fair trial under the European Convention of Human Rights 1950 Article 6 (1).
[62] AAS Zuckerman, *Civil Procedure* (London, LexisNexis Butterworths, 2003), 862.
[63] Zuckerman, Ibid, 949.
[64] Right to a fair hearing.
[65] S 6 (8) (b) ('AJA 1999').
[66] The difficulties facing applicants seeking his consent have been outlined in a previous case note on legal aid and defamation proceedings: Shipman, S, 'Defamation and Legal Aid in the European Court of Human Rights', (2005) 24 *Civil Justice Quarterly* 23, 28–32.
[67] *Aerts v Belgium* (Application No 25357/94) (1998) Reports 1998–V.
[68] Lewis (n 34), 50.
[69] *Perotti v Collyer-Bristow* [2003] EWCA Civ 1521, admittedly, not a medical case.

not to fund legal services in civil proceedings was a matter for the LSC and it was not for the court to direct the Commission to exercise its discretion to provide funding. The state's obligation to provide legal aid arose if the fact of presenting his own case could prevent the litigant from having effective access to the court. The test under Article 6(1) of the Convention was whether the court was put into a position where it really could not do justice in the case because it had no confidence in its ability to grasp the facts and principles of the matter on which it had to rule.[70]

There have, however, been successful challenges under Article 2(1) of the ECHR concerning the 'right to life' in cases where funding has been refused for bereaved families' participation in inquest proceedings. In *Humberstone, R (on the application of) v Legal Services Commission*[71] refusal to grant legal aid to a mother for the inquest into her son's death was deemed unlawful 'because the state had a duty, in some circumstances to investigate a death and if necessary, provide funding so that the investigation, including an inquest, functions properly'.[72] Hickinbottom J then provided five points of guidance for determining when the funding of representation is necessary for the purposes of an inquest. These included taking account of the view of the presiding coroner and noting that 'one factor that will not be relevant is the absence of (or restrictions on) available public funds'. He particularly emphasised that if the state is required to fund a party at an inquest to avoid a breach of the state's obligations under Article 2, it is no answer to say that money is short'.

In conclusion, it appears that although there are public law mechanisms to challenge refusals of funding for legal aid, the bar to winning is set very high.[73]

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[70] See Lewis (n 34), 50 and Haley (n 33) for further case law.

[71] *Humberstone, R (on the application of) v Legal Services Commission* [2010] EWHC 760 (Admin) (13 April 2010)

[72] Para 51. See *R (On the application of Mohammed Farooq Khan) v Secretary of State for Health)* [2003] EWCA Civ 1129. In complex cases Article 2 requires that the family of the deceased have legal representation at the inquest. Also Part III Redress within the NHS; section on inquests and coroner's court and legal representation below.

[73] The relevant dictum is set out in *X v United Kingdom* [1984] 6 EHRR136. 'Only in exceptional circumstances, namely where the withholding of legal aid would make the assertion of a civil claim practically impossible, or where it would lead to an obvious unfairness of the proceedings, can such a right be invoked by virtue of Article 6(1) of the Convention'.

G. Goodbye Legal Aid: Hello CFAs

As noted, the original idea of legal aid, introduced in 1949, was to assist people who were too poor to pay for legal representation if they were injured and sought to recover damages. Over time, the scope and range of situations where legal aid has been applied has burgeoned, often with small restraint on its mounting costs for the taxpayer and unfairness to those at the other end of disputes who were not protected by insulation against costs that legal aid usually gives its clients. It is unsurprising that governments are not enthusiastic about using taxpayers' money to fund litigation against institutions that are paid for by the taxpayer – for example, granting legal aid to people so that they can sue the NHS.[74] If the Government's consultation documents are accepted,[75] legal aid will no longer be routinely available for clinical negligence cases.[76] Instead it is proposed that there is a viable alternative source of funding in CFAs, to which I now turn. At the end of the chapter, having reviewed both legal aid and CFAs as funding sources in clinical negligence cases, I will discuss their impact on access to justice and access to the courts.

III. CFAs: THE BRAVE NEW WORLD

CFAs are defined in section 58 of the Courts and Legal Services Act (hereinafter 'CLSA') 1990, as amended by section 27(1) of the AJA 1999.[77] The importance of CFAs has significantly increased, since it is now a principle that public funding of litigation through the CLS should not be provided in cases where alternative funding (including CFAs) is available. As has been seen, legal aid has become unavailable for personal injury cases,[78] but is still available for clinical negligence cases. However, due to the means and merits thresholds discussed above, it is clear that many claimants fall

[74] D Brahams, 'Cutting Legal Aid Down to Size' (2010) 78 *Medico-Legal Journal* 4, 113.

[75] *Proposals*… (n 4) and *Proposals*… (n 5). See also, Sir Ian Magee, 'Review of Legal Aid Delivery and Governance' 3 March 2010, a critique of the workings of the LSC online at http://www.justice.gov.uk/publications/docs/legal-aid-delivery.pdf.

[76] Excepting for a few very complex cases, eg involving a disabled client. However, note that Jackson LJ, although not making any recommendation on legal aid, commented that it is vital that legal aid remains for clinical negligence and fees should be at an appropriate level. See also C Stutt, 'Who Ate All The P.I.s?' (2007) 1 *Journal of Personal Injury Law*, 81–85 who argues that any savings to the Legal Aid Fund or gains to the NHS through recovering costs in successful cases would be outweighed by additional liabilities in uplifts and premiums in successful cases.

[77] A Conditional Fee Agreement is 'an agreement…which provides for…fees and expenses, or any part of them, to be payable only in specified circumstances'. Refer to Partington (n 24).

[78] Legal aid for most personal injury claims has been withdrawn, in accordance with the Access to Justice Act 1999 and the Legal Aid Board's Funding Code from 1 April 2000.

outside of the ambit of legal aid and need to find other ways of funding their cases.[79] CFAs are the other main alternative to legal aid.[80]

I begin with a description of CFAs and how they operate in practice. This is not an exhaustive explanation but I will highlight specific problematic areas: namely, Success Fees (Uplifts), ATE Insurance and Costs. These issues will be addressed including references to case law and intimations of the suggested reforms as outlined in *Proposals for the Reform of Legal Aid in England and Wales*[81] and *Proposals for Reform of Civil Litigation Funding and Costs in England and Wales: Implementation of Lord Justice Jackson's Recommendations.*[82]

I will address the ethical uncertainties the CFA may represent for the legal profession because of its financial stake in the outcome of cases, as well as whether the proposed 'no win–no fee' system of funding clinical negligence cases will indeed achieve the Lord Chancellor's aspiration of '[p]romoting access to justice for the majority of the population in England and Wales'.[83] Unsurprisingly, this change of ethos, from a system of legal aid in which, for well over 30 years, Government-funded legal aid has played a primary role in the provision of legal services in civil litigation for those unable to pay for such services, to 'a system premised on the commercial judgement of insurers and the financial self-interest of the professions',[84] provoked consternation amongst both legal academics and practitioners.[85]

[79] Civil legal aid is available only if the claimant qualifies for it based on their income (less than £25,000 per annum gross household income) disposable capital less than £8,000 and the case satisfies the LSC's 'affordability' criteria. See S Dunn, 'Paying for Personal Injury Claims – What Are the Options for Clients and Their Representatives?' (2009) 3 Journal of Personal Injury Law 218–223.
[80] See Partington (n 24) for discussion of additional initiatives for funding and resolving cases such as alternative dispute resolution and other speculative agreements. Also M Harvey, 'Funding Personal Injury Litigation' (2003) 3 *Journal of Personal Injury Law* 03 for more detail.
[81] *Proposals…* (The Clarke Reforms) (n 4).
[82] *Proposals…* (The Jackson Reforms) (n 5).
[83] *Access to Justice with Conditional Fees* (n 25).
[84] 'The Ethics of Conditional Fee Arrangements' (January 2001) *The Society for Advanced Legal Studies, Ethics and Lawyer Fee Arrangements Working Group*, 5.
[85] Zander (n 19).

A. CFAs: Statutory Requirements

For many years, public policy, expressed through the offences of champerty and maintenance and enforced through court decisions and practice rules, had prevented lawyers from having an interest in the outcome of a case. Although the crime was abolished in the 1960s, any such agreement remained unenforceable at law.[86] Nowadays, CFAs entered into by solicitors are rescued from being champertous by s.58 of the CLSA 1990.[87] Fears about an ever-reducing access to justice due to restrictions on the legal aid budget[88] led to a fundamental change of view. The means by which this policy change was implemented was a very 'English' compromise. Parliament did not want to introduce a US-style of contingency fees for fear of creating a 'compensation culture'. Instead, in a CFA, the 'loser pays' cost rule was maintained.

1. The Success Fee

Parliament enacted that a lawyer could charge a percentage increase on his normal fee with a maximum success fee of 100 per cent. Section 58 of the CLSA 1990 was brought into force in 1995.[89] The AJA 1999 provided that, subject to rules of court, success fees (and any premiums for ATE insurance) should be paid by the loser in litigation along with other legal costs.[90] The legality of the CFA regime for all clients, not just the impecunious, was upheld by the House of Lords in *Campbell v MGN*[91] (although not without some regret and not without criticism of some of the effects of Parliament's decision).[92]

Under a CFA, the solicitor agrees to provide legal services on the basis that, unless the claim is successful, the client will pay nothing for his services. The success fee is a

[86] Balen (n 35), 75.
[87] See V Williams, 'A Species of Speccing' (2010) 2 *Journal of Personal Injury Law* 119–130 for history and case law.
[88] It has been reported that a decade ago, 52 per cent of the population was financially eligible for legal aid and this has now dwindled to under one-third. E Booth 'Beyond the Public Purse' (2009) 295 *New Law Journal* 1328.
[89] Conditional Fee Agreements Regulations 1995, SI 1995/1675.
[90] Courts and Legal Services Act 1990, s 58A (6) and (7), as amended by AJA 1999, s 27(1).
[91] *Campbell v MGN* [2005] UKHL 61.
[92] Balen (n 35), 75.

proportion of the solicitor's normal costs and not a proportion of the compensation recovered.[93]

Litigation regarding success fees has centred on the reasonableness of the level of percentage to be charged and/or the timing of such decisions.[94] For example, there have been a number of clinical negligence cases before the courts which have involved a firm that claims a success fee of 100 per cent in all CFAs that are entered into at an early stage and where the merits are uncertain. In May 2009, an appeal in *Oliver (executor of the Estate of John Oliver, Deceased) v (1) Whipps Cross University Hospital NHS Trust (2) Waltham Forest Primary Care Trust)*[95] came before Justice Jack following a reduction by the costs judge of the success fee from 100 per cent to 67 per cent (which represented a 60 per cent chance of success) in a claim on behalf of the deceased who had died of septicaemia in hospital as a result of MRSA. The costs judge had reduced the success fee on the basis that the solicitors must have thought there was more than a 50 per cent chance of success otherwise the claim would not have been pursued on a CFA basis. On appeal in *Oliver,* Jack J disagreed with the reduction to 67 per cent and reinstated the success fee of 100 per cent. Jack J ruled that a firm of solicitors was entitled to assess a claim for clinical negligence that was accepted under a CFA as having a 50 per cent chance of success, which allowed it to charge a 100 per cent success fee. The claim was of a kind that had uncertain prospects and, based on what the solicitor knew when the fee agreement was made, the claim could easily have been assessed as having chances of success lower than 50 per cent. Therefore a CFA could be entered into at an early stage and that even where a solicitor has experience of clinical negligence his 'ignorance is relative'.

This case may be contrasted with the advice in *Ku v Liverpool City Council*[96] that a staged success fee, which claims a lower success fee if the case settles at an early stage, should be applied when the merits are uncertain. Six months after *Oliver,* in another

[93] Despite this linkage with damages, it should be stressed that CFAs are related only to the professional fees charged, not damages. See *Callery v Gray* [2001] 1 WLR 2112 and 2142, the first guidance as to how risk should be assessed and success fees set. The House of Lords indicated that the Court of Appeal should be the final arbiter of judicial policy making in the new funding regime.
[94] See E Rawson, 'Funding Update' (2010) 16 C*linical Risk* 143–148 for cases and details.
[95] *Oliver (executor of the Estate of John Oliver, Deceased) v (1) Whipps Cross University Hospital NHS Trust (2) Waltham Forest Primary Care Trust)* [2009] EWHC 1104 (QB).
[96] *Ku v Liverpool City Council* [2005] EWCA Civ 475.

clinical negligence case, *McCarthy v Essex Rivers Healthcare Trust*[97] the costs judge had reduced the success fee from the usual 100 per cent to 80 per cent. On appeal, Mr Justice Mackay upheld the reduction. Mackay J, in *McCarthy*, recognised that in a typical clinical negligence claim a meaningful assessment of the risk is often not possible until the medical notes and a provisional opinion have been obtained and that thereafter a claim might be 'transformed in terms of the risk presented'. Significantly, Mackay J distinguished *Oliver* and felt that the decision in *Oliver* had understated the importance of the Court of Appeal's judgment in *Ku.*

There are now two High Court decisions giving different interpretations of *Ku.* In *Oliver*, the interpretation of Jack J was that 'it might be harder for a solicitor to justify a high fee if he has not in an appropriate case entered a two-stage agreement', whereas in *McCarthy*, Mackay J gives a more robust interpretation that, in those cases, 'it would not be possible to justify so high a success fee'. At present, there is no further guidance from the Court of Appeal, leaving scope for continuing arguments over success fees.[98]

2. ATE Insurance[99] and Disbursements

The introduction of CFAs in 1995 still left the litigant at risk of having to pay the other side's costs. Until 1 April 2000, the loser paid the basic costs in the normal way but the claimant paid his own lawyer the success fee and the ATE insurance premium. Under the AJA 1999, from 1 April 2000, the loser pays the success fee and the ATE insurance premium as well as the basic costs.[100] The Law Society's original scheme covered only the costs of the other side, but now there are forms of ATE insurance which provide cover against other risks.[101] Clinical negligence cases that are proceeding under a CFA

[97] *McCarthy v Essex Rivers Healthcare Trust* [November 2009]. High Court, HQ06X03686

[98] See Rawson (n 94) for further cases regarding different aspects of success fee litigation. Also Rowley, J, 'Is It Too Soon to Consider Prematurity?'(Or Would the Court of Appeal Decide *Callery v Gray* the Same If the Case Was Heard Today?) (2009) *Journal of Personal Injury Law* 4, 276–283 Rowley, J, 'Is It Too Soon to Consider Prematurity?' Part II (Or Would the Court of Appeal Decide *Callery v Gray* the Same If the Case Was Heard Today?) (2010) *Journal of Personal Injury Law* 1, 39−51.

[99] Before-the-event insurance is insurance already in place at the time of the clinical negligence, usually an add-on to another insurance policy such as housing or motor policy. There is often unawareness of its existence but enquiries should be made.

[100] Ss 27 and 29 of the Access to Justice Act 1999 and The Conditional Fee Regulations 2000.

[101] After the Event Cover for 'both sides' costs which would include cover for the claimant's liabilities to his own solicitor, disbursements and counsel's fee. After the Event Cover for individual claimants or in standard form by solicitors under delegated authority. For full discussion of insurance and CFAs see M Harvey, *APIL Guide to Conditional Fee Agreements*, (Bristol, Jordans, 2002).

are usually backed by ATE insurance to cover the claimant's potential liability for the defendant's costs and own disbursements if the case fails.

The majority of patients bringing clinical negligence claims cannot afford to pay for disbursements, the vast majority of which are experts' fees, throughout the litigation. There are various ways of paying these depending on the type of funding in place, but if the claimant does not have legal aid or insurance to pay the experts on an ongoing basis, market pressures will make it increasingly difficult for law firms to resist paying for disbursements. This will increase pressure on the firms to only litigate cases which appear strong on their merits.

There have been several cases which deal with the question of whether a solicitor who entered into a CFA breached the duty[102] to disclose to the client any interest which the solicitor had in recommending a specific policy of ATE costs insurance.[103] In *Ann Marriot v Greggs PLC*[104] it was held that the solicitor had materially breached the regulations, as the CFA stated erroneously that the solicitor did not have an interest in recommending a specific policy. In *Derrick Barr & Ors v Biffaste Services LTD & QBE Insurance (Europe) Ltd*[105] it was decided that ATE policies were disclosable.

3. Recoverability of the Success Fee 'Uplift' and the ATE Insurance Premiums from the Losing Defendants

The Labour Government's[106] plans to restructure legal aid included the abolition of legal aid for most types of personal injury action save for small exceptions, including clinical negligence, multiparty actions and cases involving matters of public interest and non-negligent injury, such as battery. To replace legal aid, the Government decided to reinforce CFAs with the concept of 'recoverability',[107] introduced by section 29 of the Access to Justice Act 1999. In essence, this enabled the successful claimant's solicitor to recover both the success fee and the ATE insurance premium from the defendants.

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[102] In its form under the former Conditional Fee Agreement Regulations 2000.
[103] See *Pukis v Brumby* [2008] EWHC 90095 (Costs); *Fawcett Old Ltd v Hibberd* [2008] EWHC 90102 (Cost) upheld on appeal at [2008] EWCA Civ 1375; and *Overton v Horder* [2008] EWHC 90109 in Williams (n 87).
[104] *Ann Marriot v Greggs PLC* Leeds County Court Case No 757514.
[105] *Derrick Barr & Ors v Biffaste Services LTD & QBE Insurance (Europe) Ltd* [2009] EWHC 1033 QBD (TCC).
[106] The Labour Government was in office from 1997–2010.
[107] 'Recoverability' became law on 1 April 2000.

Jackson LJ[108] supports CFAs in principle, but states that these have 'been the major contributor to disproportionate costs'. He makes a case for non-recoverability of the success fee and the ATE premium. His recommendations include preserving conditional fees, but with a cap on success fees of 25 per cent of damages[109] which will be paid by the claimant (ie not recoverable from the defendant). He then suggests that general damages for pain, suffering and loss of amenity (non-pecuniary losses) be increased by 10 per cent to offset this payment.

I would argue that the proposal to increase general damages by 10 per cent in order to compensate having to pay an up to 25 per cent success fee will not in fact compensate claimants in most cases because compensation for general damages is so low. It also undermines any meaningful significance of general damages and lends credence to my argument that payment for non-pecuniary loss within the confines of the NHS budget is futile. One argument against non-recoverability of the success fee maintains that the defendant wrongdoer should bear the costs. In addition, the low success fee will encourage solicitors to cherry-pick only the strongest cases.

Jackson LJ is particularly concerned about the defendant's liability to pay ATE insurance premiums. He found that the one-way costs shifting, that is whereby defendants bear their own costs in every case, win or lose, would be substantially cheaper. He quotes Action against Medical Accidents' (hereinafter 'AvMA')[110] comments in the final report:

> AvMA supports the idea of one way costs shifting which has been a familiar mechanism in clinical negligence where cases are funded by legal aid. AvMA does not support an unnecessary burden on the public purse of recoverability of large ATE premiums if other costs mechanism could apply.

There remains the question of non-equality of arms between defendant insurers and personal claimants.

[108] (The Jackson Reforms) (n 5).
[109] Excluding any damages referable to future care or losses.
[110] Jackson (n 5), p 84 at 3.8.

4. Costs-Only Proceedings: Civil Procedure Rule (Hereinafter 'CPR') 44.12A

Another important aspect of the regime for CFAs is the introduction of costs-only proceedings. CPR 44.12A makes provision for a new procedure for costs to be assessed where the parties have settled the substantive dispute without proceedings but are unable to agree costs. The claim is to be brought under CPR part 8, but the court must dismiss the claim if the procedure, ie CPR part 8, is opposed. Therefore, the court can only act as an arbiter if both sides agree. This means that a lawyer will need to secure the opponent's consent to this procedure before concluding the settlement of the substantive claim.[111]

B. An Alternative to CFAs: Private Funding of Personal Injury Claims

"If you can find a client who will pay your costs from start to finish, treasure him."[112]

The importance of consideration of alternative funding arrangements was emphasised in *Sawar v Alam*.[113] This case demonstrated that if, at the end of the case, it can be shown that the claimant/client had satisfactory means of funding the case other than with a CFA (involving uplifts and ATE insurance premiums) and these options had not been sufficiently explored, it would be unlikely that the firm representing him would be able to recover its success fee or ATE insurance premium. There have been technical challenges to CFAs.[114] Nonetheless, the reality is that private self-funding of most clinical negligence actions is prohibitive.

IV. IN SUMMATION: FUNDING CLINICAL NEGLIGENCE ACTIONS

So far in this chapter, I have considered and described the arrangements, both in place and projected, for funding clinical negligence actions. I have concentrated on the major sources of funding at present, namely, legal aid and CFAs. I have indicated that there

[111] For fuller discussion of costs-only proceedings please refer to F Bawdon, M Napier and G Wignall (eds) *'Conditional Fees: A Survival Guide'* 2nd edn (London, The Law Society, 2001) 38 and Harvey (n 101), ch 10.
[112] Harvey (n 101), 21.
[113] *Sawar v Alam* [2001] EWCA Civ 1401, [2002] 1 WLR 125.
[114] Harvey (n 80), 137. Please Refer to *Hollins v Russell* [2003] EWCA Civ 718 regarding the enforceability of CFAs which do not comply with statute. This article also discusses recent refinements of Conditional Fee Agreements known as 'CFA Lite'.

are major changes anticipated following the publication of both the Clarke Report and the Jackson Report. I now turn to the question of the effect the planned changes might have on access to justice for claimants suffering iatrogenic harm.

V. ACCESS TO JUSTICE: HOW WIDE ARE THE GATES?

> It is trite to say that funding is essential, but its importance cannot be overstated. If funding cannot be put in place, then a patient's claim cannot be investigated. Medical practices will be beyond accountability and deserving victims of medical accidents will not be compensated…It is equally important that remuneration, the other side of the funding coin, is sufficient to enable lawyers to be paid in accordance with their skill and expertise, and to ensure that clinical negligence work remains commercially viable.[115]

In the Introduction to this chapter I made the point that access to justice had two aspects: the availability of legal representation in the civil justice system and access to redress through extralegal routes such as the NHS complaints system.

As regards legal representation in the civil justice system, the future looks bleak for victims of medical accidents. If the proposals in the Clarke Report are accepted, clinical negligence cases will be removed from the scope of legal aid excepting special individual cases. These will depend on: the importance of the issue; the claimant's ability to present his own case, depending upon the context within which it shall be heard; the likely vulnerability of the claimant; the complexity of the law; the availability of alternative sources of funding; and the availability of alternative routes to resolving the issue. Account is also to be taken of the Government's domestic, European and international legal obligations.[116] As noted, challenges of the refusal of legal aid have not met with success, excepting representation at inquests where human rights legislation holds sway. The assumption in the Clarke Report that CFAs provide a viable alternative source of funding clinical negligence actions is only true up to a point. In order for law firms to remain financially viable, it behoves them to concentrate on cases with a more than 50 per cent chance of success. This will be even more acutely so if the Jackson Report's suggestion that success fees be reduced to 25 per cent is taken up. Again, I would emphasise that clinical negligence cases are more complex than most personal injury cases and success or failure harder to gauge at the outset.

[115] Rawson (n 94), 143.
[116] Ibid ch 4, 4163–69 for full details.

The outlook for important class actions such as the *Epilim* case, which might have resulted in one of the UK's most significant medical compensation packages, is equally bleak. This would have been a meretricious landmark case as it is thought to be the first made against a pharmaceutical company under the 1987 Consumer Act, governing companies' responsibility for the safety of their products.

As regards the recommendation in the Jackson Report for non-recovery of the success fee, offset by an increase in general damages of 10 per cent, this could leave a claimant with serious injuries without anything like sufficient funds.[117] There are additional issues arising from the recommendations. Firstly, adjustments to the level of general damages have usually been regarded as a judicial matter for the courts rather than the Government. In addition, the central purpose of an award of civil damages is to compensate the claimant for the loss or injury that he has suffered and this principle is only departed from where clear authority has been established for doing so.[118] An increase in the level of damages which is expressly made for the purpose of assisting claimants to meet their costs liabilities, rather than to compensate them for the injury suffered, would represent a fundamental change in the nature of the general damages award and would create a precedent for calls to depart from the compensatory principle in other circumstances.[119]

In conclusion, having argued for the entitlement to redress for victims of iatrogenic harm in my first chapter, it would seem to be a breach of citizens' legal rights to a fair trial[120] for them to have no practical access to representation in the civil justice system. Having exempted the more 'certain cases' which can attract CFA funding and those which may be taken into scope, the withdrawal of legal aid for clinical negligence cases represents a clear restriction of access to justice through the courts.

Whether there is a compensating extralegal route to redress is a moot point at present. The LSC in its thinking relied on the fact that victims would have recourse to the

[117] The law firm Stewarts Law have a breakdown of figures in Lord Justice Jackson's Review of Civil Litigation Costs: Final Report A response by Stewarts Law, Page 1 of 6. Point 6, downloadable as a pdf from http://www.stewartslaw.com/stewarts-laws-response-to-final-report-by-lj-jackson.aspx.
[118] For example, in the specific circumstances in which exemplary damages have been held to be available under the common law.
[119] Refer to ch 6 Damages below.
[120] Article 6 HRA 1998.

advantages set out in the Redress Act 2006.[121] The Redress Act 2006 introduces a scheme proposed by the CMO to provide victims of NHS negligence with a variety of remedies, including financial compensation, without resort to the legal process.[122] The NHS Redress Act 2006 received Royal Assent in November 2006 and was to have been implemented in April 2008.[123] Implementation has, however, been put on hold pending further consultation and likely reform of the NHS complaints procedure.[124] The NHS Redress Act 2006 is an enabling Act and much of the detail will be contained in secondary legislation. At the time of writing, July 2012, the secondary legislation has not been forthcoming. The NHS complaints system, also due for reform, has been heavily criticised in a report 'Care and Compassion?' written by the Health Ombudsman, Ann Abraham.[125] I can only conclude that at present access to justice through extralegal channels has also been diminished.

Having examined the issues related to the funding of clinical negligence actions, I now turn to the necessary components of proving clinical negligence: duty; breach[126] and causation.[127]

[121] See Chapter 8 The Redress Act 2006 below.
[122] Ibid.
[123] M Brazier and E Cave, *Medicine, Patients and The Law* 5th edn (Harmondsworth, Penguin, 2007) 270.
[124] This is due to the widely held belief that the principles of the Act are closely related to the live consultation paper entitled *Making Experiences Count* regarding NHS Complaints Procedure Reform.
[125] A Abraham, Parliamentary and Health Service Ombudsman, 'Care and Compassion?' Report of the Health Service Ombudsman on ten investigations into NHS care of older people. Presented on January 24, 2011 and printed on February 11, 2011. See Chapter 7 History of NHS Complaints below.
[126] Chapter 4 Proving Clinical Negligence below.
[127] Chapter 5 Causation below.

CHAPTER 4

PROVING CLINICAL NEGLIGENCE
DUTY OF CARE

Historically, the legal obligations of a doctor were derived from his status and 'common calling', that is, to exercise the skill and diligence expected of his calling.[1]

His Lordship reiterated that ultimately the courts, and only the courts, are the arbiters of what constitutes reasonable care. Doctors cannot be judges in their own cause.[2]

BREACH OF DUTY AND THE STANDARD OF CARE
Bolam, Bolitho, the Experts and the Claimant

Standards of prudent conduct are declared at times by the courts, but they are taken over from the facts of life.[3]

[1] The first reported cases against a doctor is *The Surgeon's Case* (or *Morton's Case*) (1374) 48 EDW 11.
[2] Lord Browne-Wilkinson in *Bolitho v City & Hackney Health Authority* [1998] AC 232, (HL).
[3] Benjamin N Cardozo, *Pokora v Wabash* Ry, 292 US 98, 104 (1934).

I. INTRODUCTION

The overall thesis examines how effectively or otherwise the civil justice system and the National Health Service[4] complaints systems address redress for patients suffering iatrogenic harm. This part of the thesis focuses on the response of the civil justice system.[5] Having considered the funding difficulties faced by would-be claimants and the negative effect financial constraints have on access to justice,[6] in this and the next chapters I concentrate on the legal rules and requirements governing proof of clinical negligence. In particular, I consider whether the requirement for the claimant to prove the elements of any successful negligence claim, namely duty, breach, causation and damage, acts as a hindrance to obtaining redress. The cases which give rise to these questions are those where there has been either a technical failure or misadventure (acts), or where there has been a failure to treat (omissions). In other words, these are cases which are associated with medical treatment in one form or another. There has been a parallel series of cases of alleged negligence arising before treatment started. These cases are based on the right of the patient to make an informed choice regarding his or her treatment. Although the principles underlying the tort of negligence are similar in both situations, the latter have developed a jurisprudence of their own which is outwith the remit of this chapter. Hence this chapter will confine itself to discussion of medical misadventure.

Most litigation against doctors concerns actions for clinical negligence. It is the principal action by which patients seek compensation for injuries caused within the NHS. The only other action which features to any extent is battery.[7] Actions in battery are rare, not least because they require the patient to prove that the doctor acted without their consent, which is not usually the case. Claims for damages generally arise out of treatment or care to which the patient has consented, but which went wrong or did not produce the desired or expected outcome. The essence of the patient's claim is that the doctor was negligent in that he breached his duty to exercise reasonable care and skill in diagnosing, advising or treating the patient.

[4] Referred to as 'the NHS' hereafter.
[5] Part II Medical Negligence Litigation.
[6] Chapter 3 Funding Litigation, above.
[7] I Kennedy, A Grubb, J Laing and J McHale, *Principles of Medical Law,* 3rd edn. (Oxford, OUP, 2010) Chapter 8.

Clinical negligence is, in reality, no more than an application of the tort of negligence to professionals such as doctors, nurses and others involved in the provision of healthcare services. Hence, the law of negligence is applicable to the medical context and medical negligence is a specific form of negligence liability in the professional context.[8] There are, however, particular factual and legal problems thrown up in the medical context which necessitate a separate account from the general principles of negligence and professional liability. A patient may have an action for breach of contract in the tort of negligence[9] or for misrepresentation.[10]

In this chapter, I will initially briefly explore problems regarding establishing: the existence of a duty of care; where liability falls; and the question of how far that duty extends. I will then turn to the question of proving that there has been a breach of that duty. I will consider the issues arising from the use of the *Bolam*[11] standard and the impact of the *Bolitho*[12] 'gloss'[13] on the assessment of medical breach. Discussion will then focus on the role of expert medical opinion in delineating the appropriate standard of care. I will touch upon the complexity of the role of the expert witness, and note the decision of the Supreme Court in *Jones v Kaney*[14] overturning the long-standing rule that expert witnesses are immune from liability for damages to parties that have engaged them and to which they owe a duty of care. I will briefly touch upon the role that guidelines play in setting the requisite standard and will raise the vexed question of the relevance of resources in framing NHS institutional liability.[15] I will conclude by considering how the rules for establishing medical negligence, in particular the rules about establishing breach of duty, affect a claimant's access to justice via the civil litigation system.

[8] J Powell and R Stewart (eds), *Jackson and Powell on Professional Negligence* 6th edn, (Andover, Sweet & Maxwell, 2007, with cumulative supplements).
[9] Kennedy et al (n 7) at 135 their footnote 19. Other actions may include false imprisonment or battery.
[10] Ibid at 135 footnote 20. Under the common principle in *Hedley Byrne & Co Ltd v Heller & Partners Ltd* [1964] AC 465, or under the Misrepresentation Act 1967, where the patient has been induced to enter into a contract for the provision of medical services.
[11] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
[12] *Bolitho (Deceased) v Hackney Health Authority* [1998] AC 232.
[13] R Mulheron, 'Trumping Bolam: A Critical Legal Analysis of Bolitho's Gloss' (2010) 69 *Cambridge Law Journal* 3, 609–638.
[14] *Jones v Kaney* [2011] UKSC 13, [2011] All ER (D) 346 (Mar).
[15] J Beswick, 'A First Class Service? Setting the Standard of Care for the Contemporary NHS' (2007) 15 *Medical Law Review* 2, 245.

On the whole, establishing the existence of a duty of care in the medical setting is not problematic. It will be obvious and accepted that a duty was owed to the claimant who was the doctor's patient. The real issues in the case will normally revolve around, for example, breach and causation. Nevertheless, there are some circumstances regarding the existence of a duty of care which briefly merit mention. These include problems where the doctor-patient relationship has not been fully forged or at all, for example: where the doctor is employed by another such as an insurance company or a prospective employer to examine the claimant; or where there is a third party who suffers injury as a result of the doctor's negligence.[16] Also, legal problems arise where the injury suffered by the patient (or another) is not personal injury but rather financial loss or psychiatric harm.[17]

II. PROVING LIABILITY: DUTY OF CARE

A. Conceptual Framework

Although no formula for testing whether in a given situation a duty of care arises has proved satisfactory, there are guidelines, of which the 'reasonable foreseeability' of harm is the most important, for it indicates a *prima facie* duty of care. However, that duty may be negated by any number of considerations, prime among which is the general consideration of policy as it appears to the tribunal trying the case.[18] The ambit of the duty of care is continually being extended gradually by *ad hoc* judicial decisions. In that way, the scope of recovery for, *inter alia*, nervous shock, economic loss, negligent misstatement, injury suffered by a rescuer and, more recently, undiagnosed dyslexia and stress-related psychiatric injury at work has been widened.[19] Some injuries are caused by circumstances where there will be no compensation – they are just bad luck.[20] Nevertheless, the claimant who has suffered personal injury[21] as a result of

[16] For example, a total stranger injured by the patient or a relative of the patient.
[17] For detailed analysis of these issues see Kennedy et al (n 7) Chapter 3 Duties in Contract and Tort. See also below Chapter 6 'Damages' for a discussion of claims for psychiatric harm.
[18] C Lewis, *Clinical Negligence*, 6th edn. (Haywards Heath, Tottel Publishing Ltd, 2006) page 175.
[19] Ibid.
[20] PS Atiyah, *The Damages Lottery* (Oxford, Hart Publishing, 1997) for a discussion of the unfairness of this very point.
[21] As distinguished from medical misadventure.

someone else's fault has a good chance of finding that compensation is available, and it is mainly in the area of pure economic losses that restrictions on tort liability arise.[22]

The picture for success in clinical negligence claims is different. It is a major difficulty for any claimant to discharge the burden which falls upon him to prove that the defendant's negligence caused his injury. The current system for compensating those sustaining injury has come under attack from all sides.[23] Patients, it is argued, have great difficulty seeking compensation for negligently inflicted medical injury and may face daunting hurdles in the process of suing the doctor. Under the NHS Litigation Authority (hereinafter 'NHSLA')[24] regime less than 4 per cent of cases now go to court, although this might not be a bad thing given that 76 per cent who do so fail.[25] It is noteworthy that, in clinical negligence cases, payment is made in some 30–40% of actions as compared with 86% in the general run of personal injury cases.[26]

B. Establishing a Duty of Care

A doctor owes you a duty of care because he *is* your doctor. That is, an automatic legal duty of care arises if a health professional has accepted to treat you, or a general practitioner has accepted you on his list.[27] A duty will also arise in the case of a private patient by virtue of his contractual relationship with his doctor (or the hospital) and, within a public national health system, the duty arises when the patient presents for treatment and is admitted.[28]

Duties in law can be assumed or imposed. The paradigm example of an assumed obligation of care is that of contract, where parties voluntarily agree to be bound to each other. As has been noted, this is not the legal basis for the operation of the NHS; rather,

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[22] This optimistic assessment of the claimant's position is from P Barrie, Compensation for Personal Injuries (Oxford, Oxford University Press, 2002) page 15 and refers to general claims for personal injury in the general run of personal injury cases. A 2nd edition of this book was published in March 2005. However, pages refer to the 2002 edition.

[23] Not least from the senior judiciary: Lord Woolf 'Clinical Negligence: What is the Solution? How can we provide justice for doctors and patients?' (2000) 4 *Med. L Internat*. 133.

[24] The NHSLA was established in 1995 to indemnify English NHS bodies against claims for medical negligence.

[25]See NHSLA Report and Accounts 2009, p 15 and JK Mason and GT Laurie, *Law and Medical Ethics*, 8th edn (Oxford, Oxford University Press, 2011), at 123.

[26] Mason and Laurie (n 25), at 113.

[27]Ibid 134.

[28]Ibid 134.

tort law dictates if and when a duty of care arises. The overarching legal and policy consideration in respect of all duties of care in tort is to ask whether it would be fair, just and reasonable to impose such a duty in the given circumstances.[29] Furthermore, the relationship between the claimant and the defendant must be sufficiently 'proximate'[30] that harm following the defendant's acts/omissions was 'reasonably foreseeable'.[31] This, in essence, is a question of how directly a claimant might be affected by the behaviour of another. The more direct the likelihood of harm, the more likely it will be that a duty of care will be imposed. This is always, however, subject to the fairness and reasonableness of creating that duty. This can be particularly problematic for relatives who claim they have been harmed as a result of negligent care of a loved one.[32] It would seem unquestionable that a public health service owes duties of care to the patients it accepts for treatment; on any analysis it is a fair and reasonable legal position.[33]

C. When a Duty of Care Arises

1. General Practitioners: Issues of Liability

A medical injury may have been caused to the claimant by any one or more of the healthcare personnel who have treated him. Locating negligence may be simple in some cases but, in others, the patient may have to choose the responsible party from a fairly large group, which may include a general practitioner, a hospital consultant or other hospital doctors and the nursing staff. Locating the specific act of alleged negligence which caused the injury may also involve a degree of disentanglement.

As noted, the existence of the doctor-patient relationship is usually obvious. However, there could be times of uncertainty about whether an individual was in fact the doctor's patient at the relevant time. Because a doctor is under no obligation to treat a 'stranger' it is important to know when the transition from 'stranger' to 'patient' takes place. The common law position is that a duty of care is imposed upon the doctor once he has

[29] *Caparo Industries plc v Dickman* [1990] 2 AC 605; *Kent v Griffiths* (N03) [2001] QB 36 and *Rees v Darlington Memorial Hospital NHS Trust* [2004] 1 AC 309.
[30] *Danns v Department of Health* [1998] PIQR P226 relationship not considered proximate.
[31] *Goodwill v British Pregnancy Advisory Service* [1996] 2 All ER 161.
[32] The issue of how far a duty of care may be extended will be addressed below.
[33] See Mason and Laurie (n 25), at 135 for circumstances where patients may be redirected to other services. It is noted that 'it is no part of the general law in the United Kingdom that a doctor must respond to someone in medical need but not his patient'.

assumed responsibility for the patient's care. Crown immunity has been extended to NHS hospital doctors, dentists and community physicians since January 1990 and, as a result, the entire costs of negligence litigation are now borne by the Health Service itself, though there is nothing to stop a claimant suing an individual doctor.[34]

2. Hospitals: Issues of Liability – Vicarious Liability and Non-Delegable Duty

The position is different if the alleged negligence occurs after the general practitioner has referred the patient for further treatment within the NHS. In hospital, the duty may arise as soon as the patient presents himself for treatment, before he is actually seen by a doctor.[35] If the negligent act is committed by a Health Service employee, the patient then has the choice of proceedings, either against the individual he thinks has been negligent, or against the Health Authority or Trust, or against both in a joint action. In practice, many actions are brought against the Health Authority or the Trust on grounds of convenience. The liability of the Authority or Trust may be based on either of two grounds: (1) the duty of a hospital to care for patients or (2) the vicarious liability of a Health Authority for the negligence of its employees.[36] Since the entire costs of negligence litigation of the NHS are now borne by the Health Service itself, this means that compensation for the injured produces limitations in treatment facilities for other patients.[37] The load is now spread in that all Trusts are encouraged to make use of the mutual insurance offered by the Clinical Negligence Scheme for Trusts operated by the NHSLA.[38] Nonetheless, litigation impacts directly upon the financial resources available to the NHS. For example, in 2009/10, the NHSLA reported a 10 per cent increase in claims over 2008/9, already an 11 per cent increase over 2007/8.[39] Legal costs are high. The costs claimed by claimant lawyers are significantly higher than those incurred by NHSLA's panel defence solicitors. The availability of CFAs[40] and the

[34] Mason and Laurie (n 25) at 129.
[35] *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428.
[36] Mason and Laurie (n 25) at 130.
[37] Ibid at 131.
[38] NHS (Clinical Negligence Scheme) Regulations 1996, SI 1996/251 made under National Health Service and Community Care Act 1990, s 21.
[39] NHSLA (website), *Key Facts About Our Work,* '£769 million was paid in connection with clinical negligence claims during 2008/09, up from £633 million in 2007/08' accessible at http://www.nhsla.com/home.htm. See also E Cave, 'Redress in the NHS' (2011) *Professional Negligence* 27(3), 138–157 at 141.
[40] See Chapter 3 'Funding Litigation' above. The Government, in Part 1 of the Legal Aid, Sentencing and Punishment of Offenders Act 2010–2012, eliminated legal aid for clinical negligence cases, which will now be funded solely through CFAs. There will remain provision for exceptional cases.

increase in their use by claimants in clinical claims has meant that claimants' costs are significantly disproportionate to the amount of damages paid, especially in low cost claims.[41]

Notwithstanding the attempts made by the Authority to avoid formal litigation, there remains a concern that the assumption of financial responsibility for legal liability by health institutions serves to divert resources away from the provision of patient care.[42] This provides a compelling reason to find creative non-financial redress for iatrogenic harm where appropriate. I argue that reparation for non-pecuniary loss (not amounting to psychiatric injury) falls into this category.

An outstanding question remains as to the extent that a hospital owes a non-delegable duty to use skill and care in treating its patients.[43] In *S v Lothian Health Board*,[44] the court allowed proof before answer on the issue of such a duty on the premise that what is relevant is whether the hospital assumes responsibility for contracted-out services that lead to negligent harm, not whether it had a degree of control over the work done.[45] This latter question of hospitals having a primary duty to provide adequate treatment becomes more significant when, as is increasingly common, a patient's NHS treatment has been contracted out to a private hospital. The NHS Trust will continue to be liable for a failure to arrange adequate care, even though it is *not* the doctor's employer. The NHS will normally have made an arrangement with the private hospital to indemnify it against liability, but the patient will be able to sue the NHS Trust.[46] Although detailed consideration of institutional liability is outside my remit, I would emphasise that there is a central public policy problem in the modern delivery of healthcare: the scarcity of resources to meet demand for services and treatment. Publicly funded health systems worldwide have come under growing pressure and the NHS is no exception to this general trend. In response, attempts have been made to utilise resources in a more

[41] NHSLA Reports and Accounts 2010 HC 52 (London, 2010), at 14. Also see Cave (n 39) at 141, footnote 30 therein.
[42] Kennedy et al (n 7) at 396.
[43] See *Garcia v St Mary's NHS Trust* [2006] EWHC 2314 (QBD). An NHS Trust, in addition to being vicariously liable for its employees, may be liable for a breach of duty owed directly to its patients. See Beswick (n 15).
[44] *S v Lothian Health Board* (2009) SLT 689.
[45] See E Jackson, *Medical Law* 2nd edn (Oxford, Oxford University Press, 2010) at 105 for further discussion and case law on this point.
[46] Ibid 107.

systematic and rational manner and difficult questions arise when an NHS body commissions care in the private sector, or refers a patient for treatment abroad.[47]

D. Health Workers and Non-Patients: Can a Duty of Care Arise?

Usually, the only person who suffers iatrogenic harm is the patient himself. However, there are various situations where a third party may be owed a duty of care by the health worker. These situations include wrongful pregnancy,[48] failure to prevent the patient from causing harm,[49] medical examinations[50] and psychiatric injury.[51] Claims for psychiatric injury are an area of special complexity which will be addressed when considering damages.[52] There have been cases regarding negligent communication of bad news[53] and fear for the future[54] where the question of duty of care was raised, but for present purposes I will be concentrating on claims by patients and/or relatives claiming for psychiatric injury occasioned by iatrogenic harm.

We have seen that the doctor's duty arises because he has undertaken or assumed responsibility for the patient.[55] What follows is a brief synopsis of the development of

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[47] Kennedy et al (n 7) at 406.

[48] *McFarlane v Tayside Health Board* 2000 SC (HL) 1. Patient's wife considered within the doctor's contemplation; *Goodwill v BPAS* [1996] 1 WLR 1397. No duty owed by doctor to future unknown partners.

[49] *Palmer v Tees Health Authority* [1999] Lloyd's Rep Med 351CA. On the facts insufficient proximity found between the health authority and the victim for it to be fair, just and reasonable to impose a duty of care on the defendants.

[50] *D v East Berkshire Community Health NHS Trust* [2003] EWCA Civ 1151. Doctor examining a child in a question of suspected abuse owed the child himself a duty of care. However in *JD v East Berkshire Community Health NHS Trust* [2005] UKHL 23 the House of Lords decided that in these situations the duty did not extend to the child's parents because this could create a conflict of interests. But see also Kennedy et al (n 7) at 189 regarding the scope of a doctor's duty to an examinee including US judgments.

[51] Ibid 108 and Lewis (n 18) at 101.

[52] Chapter 6 'Damages' below.

[53] *Allin v City and Hackney Health Authority* [1996] 7 Med LR 167 (mother told incorrectly that her baby had died. The existence of a duty of care in respect of the provision of information was conceded and the defendant held liable for its breach) and *AB v Tameside and Glossop Health Authority* [1997] 8 Med LR 91 (Health worker diagnosed with HIV and past patients were informed. Accepted on issue of duty of care but lost on issue of breach) P Balen *Clinical Negligence* Jordan Publishing Limited (2008) pages 175–6.

[54] *The Creutzfeldt-Jacob Disease Litigation Group B Plaintiffs v Medical Research Council* [2000] Lloyd's Rep Med. 161 QB 'The claimants were not defined as primary or secondary victims but rather as having a relationship to the defendants "akin to that of doctor and patient, one of close proximity",' H Teff, *Causing Psychiatric and Emotional Harm: Reshaping the Boundaries of Legal Liability* (Oxford, Hart Publishing, 2009), ch 4, p 102, fn 43 and pp 109–110.

[55] Teff, Ibid, at 126–127. 'There are distinct signs of judicial readiness to invoke "assumption of responsibility", broadly construed when finding public authorities liable.' In a sense, one can trace the ethos informing the Human Rights Act 1998 back to the historical development of the concept of trespass to the person as an actionable harm.

the law in relation to the impact that human rights legislation might have on delineating medical responsibility and patients' rights. I will also consider what extra dimension the Human Rights Act (hereinafter 'HRA') 1998 requires of public bodies, namely hospitals.

III. THE HRA 1998: DOCTORS' RESPONSIBILITIES – PATIENTS' RIGHTS

> Following the entry into force in October 2000 of the Human Rights Act 1998,…a huge tranche of legal aid money has been taken away from victims of injury and placed at the disposal of those lawyers and clients who can find some human rights basis for a claim…No lawyer dealing with any issue now is worth his salt if he cannot tag on to his claim a human rights plea. Almost every issue one can think of will have some sort of connection with one or more of the hugely comprehensive, fundamental and protean human rights recognised by the Convention, whether family, life, freedom, access to courts, fair trial or whatever.[56]

The incorporation of the European Convention on Human Rights (hereinafter 'ECHR') into domestic law through the HRA 1998[57] has had some, though limited, impact on the way in which the courts deal with claims for medical negligence.[58] The relevance of the HRA 1998 to medicine is that medical law is concerned with the fundamental nature of the relationship between doctors and patients. Medical law encompasses patients' rights to make their own decisions about how they live their lives and how they die. Patients' interests in privacy and family life, in having or not having children, are central to their dealings with healthcare professionals and the HRA 1998 makes implicit rights explicit. The HRA 1998 renders the ECHR enforceable against public authorities. However, the ECHR[59] addresses only a limited range of rights. Noteworthy is that there is no positive right to healthcare. There is no equivalent to Article 25 of the Universal Declaration of Human Rights. For the most part, what the Convention confers are negative rights – prohibitions against certain kinds of infringements of basic freedoms.[60] The area where human rights litigation best flourishes concerns the liberty of the subject.[61] The significant areas for concern are where what is at stake is a failure by the NHS to

[56] Lewis (n 18) at 444.
[57] To be referred to as HRA 1998.
[58] See M Jones *Medical Negligence* 4th edn (Andover, Sweet & Maxwell, 2008), 59–68 for detailed case material.
[59] The Convention to which the 1998 Act gives domestic effect.
[60] M Brazier and E Cave, Medicine, Patients and The Law 5th edn (Harmondsworth, Penguin, 2011) chapter 2 for a full discussion of the HRA 1998 and domestic medical law.
[61] For example in issues surrounding the detention of mental patients, *R v Camden & Islington HA, ex p K* (2001) cited in Lewis (n 18), chapter 27.

provide certain sorts of care, or concerns about allowing insurers to demand medical details. The utility of the Act still needs to be tested.[62]

Article 2 of the ECHR provides that 'Everyone's right to life shall be protected by law'.[63] Article 2 imposes on the State a positive obligation to intervene to protect people whose lives are at real and immediate risk.[64] In terms of hospital care, Article 2 is likely to be engaged in cases where death has or may have been caused by a lack of adequate systems to protect the lives of patients and the patient is detained, either as a prisoner or as a patient sectioned under the Mental Health Act.

A recent and useful example of the court's approach to the application of Article 2, the right to life, may be found in *Savage v South Essex Partnership NHS Foundation Trust*.[65] In brief, Mrs Savage had been detained under section 3 of the Mental Health Act 1983. She suffered from schizophrenia, but it was not considered necessary for her to be in a locked ward. She walked out of the hospital, proceeded to a railway station, jumped in front of a train and suffered fatal injuries. Her daughter brought a claim alleging breach of Article 2. There was no claim in negligence. The Trust applied for determination of the proper test to establish a breach of Article 2.[66]

It was established that the State's obligation to protect life under Article 2 imposed three different duties upon the State: (1) a negative duty to refrain from taking life, (2) an implied positive duty properly and openly to investigate deaths for which the State might bear some responsibility and (3) a duty to take positive steps to protect the lives of those within the State's jurisdiction. This case was about the third duty. The principal component of the duty to protect life was an effective system of criminal law to deter people from taking other people's lives and to punish those who did. However, the duty goes further than that. In certain well-defined circumstances, there is a positive

[62] M Brazier and E Cave, *Medicine, Patients and The Law* 5th edn (Harmondsworth, Penguin, 2007) 47.
[63] Brazier and Cave (n 60), at 39.
[64] *Osman v UK* (1998) 29 EHRR 245.
[65] *Savage v South Essex Partnership NHS Foundation Trust* House of Lords, 10/12/08. Analysis from J Mead, 'Application of Article 2 to patient suicides: *Savage v South Essex Partnership NHS Foundation Trust*' (2009) *Clinical Risk* 15, 85–88.
[66] Two of the five Law Lords gave substantive judgments and all agreed the Trust's appeal should be dismissed. The summary is taken from Lady Hale.

obligation on public authorities to take preventative measures to protect an individual whose life was at risk from the criminal acts of another individual.[67]

The question at issue was what would trigger the obligation in a clinical setting. The Trust cited *Powell v UK*[68] where the European Court of Human Rights (hereinafter 'ECtHR') had ruled that, where a State made adequate provision for securing high professional standards among medical practitioners, negligence by doctors did not, of itself, constitute a breach of Article 2. However, the court applied the test in the rulings in *Osman and Keenan v* UK,[69] namely:

> Whether the authorities knew, or ought to have known, that the deceased posed a real and immediate risk of suicide and, if so, whether they did all that could reasonably be expected of them to prevent that risk.[70]

The trigger of 'real and immediate risk to life' had rarely been demonstrated in the reported cases. Competing values in the Convention had to be considered by public authorities. For example, keeping a patient absolutely safe from physical harm by secluding or restraining her, or even by keeping her in a locked ward, may do more harm to the patient's mental health. The court's ruling included a comment that this approach should not persuade professionals to behave any more cautiously or defensively than they are already persuaded to do by the ordinary laws of negligence. However, it remains unclear where this ruling leaves the NHS. John Mead's view is that it is likely to persuade Trusts to take a 'safety first' approach, which may mean a more restrictive regime for patients.[71] He concludes that, as with many leading decisions, the true significance of this one will only become clear once following cases have been before the courts. The NHS can expect to see an increase in Article 2 challenges.[72]

I have included this discussion of the HRA 1998 because the Act has the potential to transform medical law and offer a clearer articulation of patients' rights.[73] One example of this would be regarding provision of care. As the pressure for scarce NHS resources becomes ever more acute, decisions regarding allocation will be framed in the language

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[67] *Osman v UK* (n 64).
[68] *Powell v UK* [2000] 30 EHRR CD 362.
[69] *Osman and Keenan v UK* [2001] 33 EHRR 913.
[70] *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74 per Lord Roger at 19.
[71] Mead (n 65).
[72] For further decisions and discussion see Kennedy et al (n 7) at 256.
[73] Brazier and Cave (n 60) at 59.

of competing rights. How restrictively, or otherwise, the courts interpret the scope of the duty of care owed by public healthcare providers will be determinative in these cases.[74] One positive impact of the HRA 1998 has been to encourage the judges to scrutinise public authorities' decisions more vigorously, particularly where life is at stake.[75]

IV. BREACH OF DUTY AND STANDARD OF CARE

A. Introduction

> The common law, it can be argued, progresses, not just over the longue durée from time immemorial to the present, but also from case to case.[76]

There are a number of difficulties a claimant faces in proving negligence. They include the problem of ascertaining exactly what was done in the course of treatment, of securing expert evidence which will allege and substantiate a want of due care, of proving a causative link between the treatment and the injury and of overcoming any possible pro-doctor prejudice in the mind of the judge and, if matters go further, the appeal court.[77] In this section of the chapter, I shall be concentrating on the necessary elements a claimant must prove to show that there has been a breach of duty. Where, as seen, claimants on the whole will find little difficulty in showing that a duty of care is owed by the doctor to his patient, the issue of the standard of care and whether the defendant has failed to meet that standard is a central issue in an action for medical negligence.[78] The action will only succeed if the defendant/doctor has not attained the requisite standard of care and the claimant proves this.

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[74] For discussion of the obligation to provide medical care see Kennedy et al (n 7) at 259. See the requirement of reasoned judicial decisions to comply with Article 6: infra in the section on expert opinion.

[75] Brazier and Cave (n 60) at 59.

[76] JA Harrington, 'Progress Through Pluralism: Towards an Epistemology of Medical Negligence Law' *EUI Working Paper* LAW No. 2002/12, p 16.

[77] See Lewis (n 18), chapter 22 regarding difficulties for the claimant in finding medical experts and the issue of judicial bias towards doctors.

[78] See above regarding 'duty of care'. The claimant will usually not have any difficulty showing that he was owed a duty of care by health professionals, usually in tort/and or contract. In order to restrict the scope of potential claims, the courts have however, placed some restrictions on claims for psychiatric injury and 'wrongful conception', 'wrongful birth' and 'wrongful life' actions. See above.

I will first consider the *Bolam*[79] and *Bolitho*[80] tests. The traditional test the English courts have adopted to define the standard of care is known as the '*Bolam* test'.[81] This test, perceived as 'making doctors judges in their own case',[82] has come under increasing criticism[83] in the current less deferential and more iconoclastic age. This section will first set out the extent of the '*Bolam* test' and will then discuss the more recent '*Bolitho*'[84] decision, wherein the court will be seen to have taken a more active role (vis-à-vis the medical profession) in the evaluation of what the standard of care should be in specific instances.

I will then discuss the significance of expert opinion and guidelines in setting out the requisite standard of care. Once the standard of care is set, the second stage of deliberation requires a decision about whether, on the facts of the case (as determined from the evidence), the defendant's conduct fell below the appropriate standard. This is a question of fact. Although these two stages are logically discrete, in practice it may be difficult to separate findings of 'fact' and value judgements about the defendant's conduct. It is because the question of standards, guidelines and medical expert opinion is pivotal in both the legal and NHS investigations of medical misadventure that I am addressing the problem.

B. Not Yet Bye-Bye Bolam: Factors Triggering the Bolitho 'Gloss'

1. Introduction and Context

One of the crucial issues before us is the extent to which accepted professional practice dictates the standard of care in medical negligence. Until well into the twentieth century, the standard, as commonly formulated in the cases and mediated through the jury, provided considerable scope for external evaluation.[85] Consistent with general negligence principles, liability was said to depend on failure to exercise reasonable care and skill in the circumstances. Decisions ultimately rested on how juries interpreted the

[79] *Bolam v Friern Hospital Management Committee*, [1957] 1 WLR 582.
[80] *Bolitho* (n 12).
[81] Taken from McNair's J direction to the jury in *Bolam* (n 79).
[82] Lord Browne-Wilkinson (n 2).
[83]See M Brazier and J Miola 'Bye-Bye Bolam: A Medical Litigation Revolution?' (Spring 2000) 8 *Medical Law Review* 85–114 page 85 footnote 2 for critical academic comment references.
[84] *Bolitho* (n 80).
[85] J Miola, *Medical Ethics and Medical Law*, (Oxford, Hart Publishing, 2007) at 11.

requirements of reasonable medical practice as articulated by the judge. To that extent, liability could be described as rooted in community standards.[86] Expert evidence on the expectations and customary practice of the medical profession played an important part but was not seen as dispositive. The primacy of the jury's evaluative role was a distinctive feature of judicial directions in the leading nineteenth and early twentieth century cases.[87] From the 1950s onwards, a different picture emerges. The civil jury had all but disappeared and judicial evaluation of medical conduct was to be constrained by the direction in *Bolam v Friern Hospital Management Committee*[88]or more precisely, by the interpretation of certain passages in McNair J's summing up. Most important of these was the assertion which has become known as the '*Bolam* test': that a doctor is 'not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art… merely because there is a body of opinion who would hold a contrary view'.[89] The test, as normally applied, precluded a finding of negligence if one or more medical experts satisfied the court that such a responsible body existed.[90] In Lord Scarman's words, '…the standard of care is a matter of medical judgement.'[91]

Endorsement by the House of Lords of the 'accepted medical practice' defence was to prove wide-ranging. It embraced, but went well beyond, diagnosis[92] and treatment,[93] the …heartland of the skilled medical practitioner,'[94] substantially enlarging the role of the doctor as moral arbiter in the process.[95]

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[86] This approach is described as 'normative' by J Miola and would have allowed the court to say 'what ought to have been done in the circumstances' following *Hunter v Hanley* [1955] SLT 213. See Miola Ibid at 11.

[87] See summing up in *Rich v Pierpoint* (1862) 176 ER 16 at 18–19, per CJ Erle: '...it was an action charging (the defendant) with a breach of his legal duty, by reason of inattention and negligence and want of proper skill and care; and if the jury were of the opinion that there had been a culpable want of attention and care, he would be liable…' quoted in H Teff, 'The Standard of Care in Medical Negligence – Moving on from *Bolam'* (1998) 18 *Oxford Journal of Legal Studies* 3, 473 at 473–4.

[88] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (Bolam).

[89] Ibid at 587.

[90] Today one would look to the standards and guidelines of the relevant Royal College.

[91] *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] 1AC 871 at 881.

[92] *Maynard v West Midlands Regional Authority* [1984] 1 WLR 634.

[93] *Whitehouse v Jordan* [1981] 1 WLR 246.

[94] *Rogers v Whitaker* [1992] ALJR 47 at 52.

[95] For further examples refer to H Teff (n 87) at 473–4. In J Miola's terms 'a descriptive approach to medical conduct', which leaves the medical profession to judge itself. Miola (n 85) at 12.

On the whole, the courts have been loath to take issue with clinical judgement that has been endorsed by expert testimony. However, in the last decade, they have been increasingly prepared to question medical conduct, test the reasoning behind clinical decisions and non-disclosure of risks and even, on occasion, override expert medical evidence.[96] As Lord Browne-Wilkinson stated in *Bolitho*, referring to clinical judgement:

> '…if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible'.[97]

Below, I will consider the extent to which current judicial attitudes towards clinical judgement mean that the courts make their own risk-benefit analysis and exercise the traditional role of a tribunal of fact: to decide whether or not the defendant's conduct was reasonable — in short, the impact of *Bolitho* on the application of the *Bolam* test.[98]

2. The '*Bolam* Test'[99]

> John Hector *Bolam* was very depressed before he began his medical negligence claim. This was why he was given the Electric Shock Treatment (ECT) which resulted in the injuries which caused him to sue. I am certain he was even more depressed at the end of his case, not only because he lost it, but because he found that he had unwittingly given his name to the legal principle which caused him to lose it.[100]

At the trial of his negligence claim against the hospital, the diagnosis of depression was not in question, nor was the decision to use ECT. What was in dispute was whether, prior to the administration of the shocks, Mr Bolam should have been given muscle relaxants and/or restrained on the table. At that time, professional practice varied widely

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[96] *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334; *Newell and Newell v Goldenberg* [1995] 6 Med LR 371.
[97] *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 1151, HL at 1160.
[98] Mulheron (n 13).
[99] 'For his name is known throughout the world, in every jurisdiction in which the English Legal System prevails or is the model, because his case, *Bolam v Friern Hospital Management Committee* (1957) has long stood as the leading case on the standard of care expected by law of the medical and surgical professions. It has withstood various attempts in this country to diminish or abolish it and the principle at its heart (which many have claimed over the years is too favourable to defendants) still holds sway here, though now with a more critical eye cast over it before it is applied in its strictest form.' J Badenoch QC 'Brushes with *Bolam*. Where will it lead?' (2005) 72 *Medico Legal Journal* 4, 127–142. *Address to Medico-Legal Society* (11 March 2004).
[100] Ibid. See J Miola, *Medical Ethics and Medical Law*, (Hart Publishing, 2007) at 10 for details of the operation.

about the use of drugs and physical restraint and in relation to whether patients should be warned of the risk of fracture. Experts disagreed. The case was heard before a jury, as was usual with personal injury claims in England at the time. The trial judge, Mr Justice McNair, had to give directions to the jury on the law to apply when deciding whether the omission of restraints was negligent. Faced with the conflicting medical views on the matter, he directed the jury as follows:

> The test is the standard of the ordinary skilled man exercising and professing to have that special skill. He need not possess the highest expert skill at the risk of being found negligent. It is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.[101]

This first part of the judgment is unremarkable and not far removed from the 'reasonable man' test which applies in other spheres of life. The defendant need not attain the 'highest expert skill' but must have achieved the ordinary level of competence expected of a person in his profession practising the same speciality. The next part of the judgment is more problematic:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in a particular art...Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.[102]

The difficulty this part of the judgment presents is that the core dispute in professional negligence cases which are defended often centres on just what does constitute 'proper practice' or 'ordinary competence' in relation to the procedure in dispute. If the profession itself cannot agree whether or not a particular practice amounts to adequate care of the patient's or client's interests, judges have been reluctant to intervene to second-guess the opinion held, reasonably, by one body of opinion within a profession. Margaret Brazier and José Miola[103] and James Badenoch[104] argue that, although the same considerations apply to all professions, what distinguished medical litigation from other areas of professional liability, at least before *Bolitho*, is, in part, that a series of judgments gave rise to a perception that all *Bolam* requires is that the defendant fields

[101] *Bolam* (n 79) (McNair J.)
[102] Ibid at 586.
[103] Brazier and Miola (n 83).
[104] Badenoch (n 99).

experts from his medical speciality prepared to testify that they would have followed the same course of management of the patient as did the defendant.[105] Brazier and Miola contend that, Before *Bolitho*, assuming the expert opinion had genuine probative value, neither the expert nor the defendant would be asked to justify their practice; the judge would play no role in evaluating the expert opinion.[106] The extent to which the *Bolam* rule regarding differing practices obtains in professional contexts other than medicine is unclear. Judicial lack of challenges in medical cases has been compared unfavourably with its handling of other professions.[107]

The *Bolam* test of breach, with its genesis being a defendant's reliance upon a body of responsible peer professional opinion, is the 'universal test'[108] of professional negligence. It is qualified, however, by the 'gloss' that was applied, courtesy of the House of Lords' 1997 decision in *Bolitho.*[109] By virtue of that decision, peer professional opinion which purportedly represents evidence of responsible medical practice can be departed from if that opinion is determined by the court to be 'not capable of withstanding logical analysis' or is otherwise 'unreasonable' or 'irresponsible'. In a case analysed according to *Bolitho* principles, the court, not the medical profession, becomes the final arbiter of medical breach. The issue addressed below concerns *what features* particularly characterise a peer professional opinion as one that is 'illogical', 'irresponsible' and 'indefensible' — in other words, what situations trigger a *Bolitho* 'gloss'.[110]

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[105] See Lord Scarman's judgment in *Maynard* (n 92) (HL): "It is not enough to show that there is a body of competent professional opinion which considers that there was a wrong decision, if there also exists a body of professional opinion equally competent, which supports the decision as reasonable in the circumstances. In the realm of diagnosis and treatment, negligence is not established by preferring one body of professional opinion to another." See also *De Freitas v O'Brien* [1993] 4 Med L R 281 and *Whitehouse v Jordan* (n 93) (HL). Brazier makes the same point with regard to consent cases and care of incapacitated patients.

[106] Brazier and Miola (n 83) quote M Jones in his *Medical Negligence* London, Sweet & Maxwell, 2nd edn (1996) who suggested that 'judges may have found it difficult to find against members of the medical profession on questions of negligence, given that out of six medical negligence claims before the House of Lords in 16 years the 'score' was *Plaintiffs 0; Defendants 6.*

[107] Brazier and Miola (n 83). See *Edward Wong Finance v Johnson Stokes and Masters* [1984] AC 296 where the Court found prevailing conveyancing practices negligent.

[108] The *Bolam* test now applies to any profession which requires special skill, knowledge or experience: *Gold v Haringey* HA [1998] QB 481 at 489.

[109] *Bolitho* (n 12).

[110] Mulheron (n 13) at 610.

3. *Bolitho*: from the Descriptive to the Normative

The medical malpractice claim brought on behalf of Patrick Bolitho which culminated in the judgment of the House of Lords in *Bolitho v City & Hackney Health Authority*[111] was an unlikely candidate to become a landmark case regarding the standard of care because the central question in dispute was a problem of causation rather than breach of duty. Nonetheless, in *Bolitho,* the House of Lords adopted a more robust and potentially less deferential version of the *Bolam* test. Patrick Bolitho, who was two years old, had been admitted to hospital suffering from breathing difficulties. His condition deteriorated and he suffered a cardiac arrest, leading to brain damage and subsequently to his death. The on-duty paediatric registrar did not see him, but even if she had, she said that she would not have intubated him. Intubation was the only procedure which could have prevented respiratory failure, but it was not without risks. The expert witnesses for each side expressed diametrically opposed views about whether a failure to intubate would have been reasonable. On the facts, the House of Lords held that the registrar had not breached her duty of care, but the case is important for Lord Browne-Wilkinson's comments on the circumstances in which the court would decide that there had been negligence, despite experts agreeing with the defendant's course of action.[112] Lord Browne-Wilkinson held that this plurality of views did not automatically decide the issue in favour of the defendants. He acknowledged that it will be a 'rare' or 'exceptional' case where judicial intervention will be justified: 'it will seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable'.[113] Nevertheless, 'the law has been put back on its proper course: clinical judgements will, in all probability, remain untouched by the court's reviewing eye, as *Bolitho* shows, but they will be subject to it and that is a very important reaffirmation of the court's role'.[114] In *Bolitho*, then, the House held that the descriptive interpretation was no longer to be used and that the test would be normative instead. In order to qualify as a responsible or reasonable body of opinion, expert evidence had to be logically defensible.[115]

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[111] *Bolitho* (n 12), (HL).
[112] Jackson (n 45) at 117.
[113] *Bolitho* (n 12), n.441 therein.
[114] A Grubb, 'Problems of Medical Law' in S Deakin, A Johnston and B Markesinis, *Markesinis and Deakin's Tort Law* (Oxford, Oxford University Press, 2003) 318.
[115] Brazier and Miola (n 83).

a) Bolitho *in Action*

The *Bolitho* test has had a tangible impact on medical jurisprudence but the unexpressed or non-explicit instances of its application unfortunately conceal the effect of the 'brake' which it is applying to *Bolam.* Although originally regarded as a 'rare occurrence', the *Bolitho* test, while not *commonly* trumping *Bolam*, has changed the outcome of medical negligence lawsuits in more cases than the label of 'rarity' would suggest.[116] The number of cases in which *Bolitho's* gloss has been invoked,[117] is not so low as to be labelled 'rare'; and the scenarios in which the courts have considered *Bolam* evidence to be lacking logical analysis are repetitive enough to comprise recognisable categories, yet reasons varied as well. The categorisation of *Bolitho* factors covers a range of scenarios in which the expert evidence was not defensible. Some factors pertain to credibility; others require a close examination of why experts advocated certain medical diagnosis or treatment for that patient which have nothing to do with credibility but speak to the comparative weighing of risks and benefits. Close analysis of the standard obtained in the case by the defendant is necessary to retain cogency and clarity and, I would argue, fairness to both parties in litigation.

In totality, Rachael Mulheron[118] notes the following seven factors which have emerged post-*Bolitho*, by which to test whether Lord Browne-Wilkinson's labels – 'illogical' and 'irrational' – can be made out, so as to override approved medical practice under the *Bolam* test. The court must consider whether the doctor's expert testimony:

- took account of a clear and simple precaution which was not followed but which, more probably than not, would have avoided the adverse outcome;
- considered conflicts of duties among patients and resource limitations governing the medical practice;[119]
- weighed the comparative risks/benefits of the medical practice, as opposed to other course(s) of conduct;
- took account of public/community expectations of acceptable medical practice;[120]

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[116] See Mulheron (n 13) for a careful analysis of *Bolam/Bolitho* features in a variety of cases.
[117] Ibid. Over 20 cases are discussed in the article.
[118] Ibid at 637.
[119] See *Garcia v St Mary's* (n 43) discussed above regarding resource allocation.
[120] See *Nationwide Organ Retention Group Litigation* Order No. 9. The jointly-agreed expert evidence was that in 1992 the practice was not to be explicit with parents about the details of the post-mortem

- was correct in light of the factual context as a whole;
- was internally consistent; and
- adhered to the correct legal test governing the requisite standard of care.

4. *Bolam, Bolitho* and Access to Justice

Adhering to the *Bolam* test, a doctor who is accused of negligence need only present expert opinion to the effect that he has 'acted in accordance with a practice accepted as proper by a responsible body of his professional peers' and he will be absolved of negligence. The doctor's expert's evidence thus becomes conclusive of the question of breach of duty.[121] The test has been seen as being 'over-protective and deferential' towards doctors leading to the perception that the medical profession was 'above the law'.[122] The *Bolam* test was also seen to deprive the courts of the opportunity of 'precipitating changes where required in professional standards' and being 'dictated to' rather than exercising their own judgement. Additionally, there was the view that *Bolam* did not necessarily protect the community against unsafe medical practices and that more judicial safeguards for the public were required. It was also contrary to the increasingly 'rights-based society' to dismiss patients' concerns as obviously as the *Bolam* test countenanced. The overarching criticism of *Bolam* was that the medical profession was seen to set its own standards irrespective of whether the practices adopted by the profession provide an adequate protection for patients.[123] While *Bolitho* may herald a new dawn in the proclamation of judicial authority over medical practice, cases since decided have sent mixed messages.[124] However, the new ethos should be seen in the context of other developments in the manner in which medical practice is regulated and audited, which place limits on unfettered clinical autonomy,[125] thereby theoretically extending access to redress for victims of iatrogenic harm.

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examination. The court accepted the parents' claim that *Bolam* could not operate to defend this medical practice. See Mulheron (n 13) at 629.

[121] Ibid at 612 and also known as 'the custom test of negligence' A Merry and A McCall Smith, *Errors, Medicine and The Law* (Cambridge University Press, 2001) at 166.

[122] Ibid.

[123] Merry and McCall Smith (n 121) at 167. Also Jackson (n 45) at 117.

[124] Brazier and Cave (n 60) at 189.

[125] See Chapter 7 'History of NHS Complaints' below.

> The classic exposition of the duties of expert witnesses was laid down by Cresswell in *Natural Justice Cia Naviera SA v Prudential Assurance Co Ltd. The Ikarian Reefer* [1995] 2 LI Rep 68. The key features are that the expert must be independent; never assume the role of an advocate; never ignore or omit relevant material; inform the court if his view changes; and tell the court if something is out of his expertise.[126]

1. Experts

In the context of medical negligence litigation, expert evidence on both liability and causation will normally be crucial to the outcome of the case. Cases can be won or lost on the quality of expert evidence. The technical legal issues of privilege, confidentiality, disclosure, conflicts of interest, single or more experts to keep equality of arms and the Protocol for the Instruction of Experts to give Evidence in Civil Claims[127] are outwith the remit of the thesis and are extensively covered elsewhere.[128] There are, however, concerns about the dynamics of providing expert evidence for the purposes of adversarial litigation. Expert witnesses wield considerable power and influence in both civil and criminal cases. Obtaining an expert has historically proved challenging for the claimant, but providing expert opinion can also be fraught.

It is common knowledge that it has, in the past, been extremely difficult to prove that a doctor has been negligent. One of the reasons given for this is that it was difficult to find an expert willing to accuse a colleague. This has been referred to as the 'closing ranks' syndrome, contributing to patients' difficulties, particularly where the speciality concerned is a narrow one. Greater expertise in choosing experts means that presently it is easier to get a fair assessment of a patient's treatment.[129] Nevertheless, judicial deference to the medical profession still leaves an echo and that, coupled with judicial inexperience whereby complex claims are often heard by a judge with no background in

[126] C Williams, 'The Trouble with Paediatricians' (2010) 18 *Medical Law Review* 3, 389 fn 49 therein.
[127] *Protocol for the Instruction of Experts to give Evidence in Civil Claims* Published by Civil Justice Council (June 2005). The Expert Witness Institute was launched in 1996 to service and support experts.
[128] Jones (n 58), ch 13 p 1115 and Lewis (n 18), ch 9.
[129] Lewis (n 18) at 320.

medical matters, may leave the claimant at a disadvantage.[130] Many, if not most, medical negligence trials are decided by the judge's preference for the evidence of one expert rather than another.[131] In *English v Emery Rheinbold & Strick*,[132] a personal injury claim, the Court of Appeal gave guidelines on how and when to appeal on the grounds that the trial judge's reasons for his decision were inadequate. It was also clear *inter alia* that it was the judge's duty to produce a judgment that gave a clear explanation for his order.[133] Therefore, the quality of the expert evidence and the manner in which it is given is so important that judicial comments on experts in all medical negligence cases are now collected on the *Database of Medical Litigation*.[134]

a) The Expert's Duty

> Aspiring medical expert witnesses would do well to bear this case in mind – an expert witness can win or lose a case.[135]

In medical cases, any course of action (ceasing/continuing treatment) typically entails certain risks and the question is always whether the physician balanced those risks properly. In a negligence action, the expert will be called upon to establish that the doctor did not act as a reasonable doctor[136] skilled in the particular speciality would have done.[137] The expert has a duty both to the court and to those from whom he has received instructions, the former being the more crucial. The Civil Procedure Rules (hereinafter 'CPR') at part 35.3, provide that it is the duty of an expert to help the court

[130] Ibid 321 and 332. See also T Karen-Paz, 'Liability Regimes, Reputation Loss and Defensive Medicine' (2010) 18 *Medical Law Review* 363 at C "Strict Liability as Insurance"'…cautious physicians might fear judicial error…'
[131] *Maynard* (n 92) at 638, HL. Per Lord Scarman.
[132] *English v Emery Rheinbold & Strick* [2002] 1 WLR 2409.
[133] Lewis (n 18) at 333. A reasoned decision is also needed to comply with Article 6 of the ECHR.
[134] Ibid 332. See also Teff (n 87) at 481 about how expert testimony can become compromised.
[135] RG Notley, 'Expert Witness Criticised' (2011) 17 *Clinical Risk* 1–7 referring to a hearing in the Family Division (www.bailii.org/ew/cases/EWHC/Fam/2009/2115.html).
[136] Note: the test is of a reasonable doctor (*Bolam* (n 79)); assessed at the time of the alleged negligence (*Roe v Minister of Health* [1954]2 QB 66); at the standard of the post (*Wilsher v Essex Area Health Authority* [1987] QB 730). See Jackson (n 45) at 127.
[137] The court is the trier of fact decided by the judge. Expert evidence is opinion evidence which is a significant exception to the general inadmissibility of statements of opinion. Merry and McCall Smith (n 121) at 176.

on matters within his expertise and that that duty overrides any obligation to the person from whom he has received instructions or by whom he is paid.[138]

> The Court… needs and depends upon the help it receives from experts. The expert advises, but the judge decides – on the evidence. If there is nothing before the Court which throws doubt upon the expert evidence then the court must accept it. The Court relies upon the medical expert witness to be up to date, to be honest and to be familiar with the relevant medical literature. Agreeing to act as a medical expert witness is not a decision to be taken lightly.[139]

In *Jones v Kaney*,[140] the Supreme Court addressed the question of whether expert witnesses should remain immune from negligence actions in respect of their court work. The Supreme Court, in its wide-ranging judgment, took the opportunity to consider the broader issue of whether public policy 'justifies conferring on an expert witness any immunity from liability in negligence in relation to the performing of his duties in that capacity'.[141] The issues canvassed include the current state of the law, the reasons for the immunity, comparison with the position of barristers, and discussion of the foreseeable consequences of removing the immunity of expert witnesses. After noting the court's decision, I will highlight and discuss some of the court's concerns and how access to justice might be affected.

b) Expert Witness Immunity: Jones v Kaney[142]

In this professional negligence action, the defendant psychologist, Mrs Kaney, raised the defence of witness immunity, relying on the Court of Appeal decision in *Stanton v Callaghan.*[143] She applied to strike out the claim. Handing down judgment on 21 January 2010, Blake J held that *Stanton v Callaghan* was still good authority, was binding on him and he was required to strike out the claim. However, because he considered that a policy of blanket immunity for all witnesses was too broad, the case was certified as being suitable for a leap-frog appeal to the Supreme Court under section

[138] CPR Part 35.3; but note an expert is defined as 'one who has been instructed to give or prepare evidence for the purpose of court proceedings r 35.2. See also Lewis (n 18) at 123 'What the Court Expects of the Expert' and at 126 'What the Lawyer Expects of the Expert'.
[139] Ibid at 1.
[140] *Jones v Kaney* (n 14).
[141] *Jones v Kaney* (n 14) per Lord Phillips at para 2.
[142] *Jones v Kaney* (n 14).
[143] *Stanton v Callaghan* [1999] 2 WLR 745. The leading case on immunity conferred in respect of a claim brought by a litigant against his own expert witness.

12 of the Administration of Justice Act 1969.[144] The Supreme Court, by a majority of five to two (Lord Hope and Lady Hale dissenting), allowed the appeal.[145] The question remained whether the principle that 'Where there is a wrong there must be a remedy' was more pressing than countervailing factors, such as a fear of deterring potential expert witnesses from agreeing to act or the additional insurance costs. This final point, to which I shall return, speaks directly to the question of access to justice and redress for a wrong.

2. Experts' Immunity: The Public Policy Aspect and Reluctance to Testify

Expert's immunity is a long-standing principle of English law with roots as far back as 1585. The justification for immunity has traditionally centred on public policy issues, including the need to ensure that witnesses are able to give their evidence freely and in accordance with their duties to the court. The immunity exists, then, not for the benefit of the expert as such, but for the public policy requirement that all witnesses, including expert witnesses, should not be inhibited from giving frank and fearless evidence. So far as the expert witness is concerned, this avoids the tension between a desire to assist the court and the fear of the consequences of a departure from advice previously given to the client. The limits to this protection are based around the fact that its foundation is the need to protect the integrity of the court process and the witness's role in it.[146]

Lord Phillips, giving the leading judgment, addressed this issue and challenged the justification for experts to be immune on the assumption that experts would be reluctant to testify through fear of being sued. When considering if experts would still give full and frank disclosure to the court in accordance with their overriding duty as set out in the CPRs at part 35.3, Lord Phillips compared expert witnesses to advocates whose immunity was abolished in 2000.[147] He noted that in his experience, the removal of

[144] See C Passmore, 'Expert Witness Immunity: The End of the Road?' (2011) 17 *Clinical Risk* 8–11 at 10 for Blake J's reasoning for expediting the case to the Supreme Court. This included concern that 'an overbroad immunity from suit to apparently privileged parties raises questions of right of access to a court under Article 6'.
[145] Ben Hardiman, Mills & Reeve LL.P. 'Experts' immunity from suit' Insurance Briefing Jones v Kaney, at www.mills-reeve.com/insurance-briefing-Jones-v-Kaney-03-30-2011.
[146] Passmore (n 144) at 8. Note: the expert was not immune at the advisory stage including preparation of advisory report.
[147] *Arthur JS Hall and Co. v. Simons* [2000] 3 WLR 543. At 552–553, Lord Steyn considered whether removal of an advocate's immunity would undermine his overriding duty to the court and concluded that it would not.

immunity from advocates had not resulted in any diminution of the advocate's readiness to perform that duty. Lord Phillips denied that an expert would be torn between his dual responsibilities to the court and to his clients.[148]

There are two issues here: the quality of experts' evidence if immunity is removed and the 'chill factor' as regards the availability of willing experts. I would argue that most expert witnesses, being conscientious professionals, would feel themselves unlikely to be found negligent and would nonetheless carry indemnity insurance. In fact, existing professional disciplinary risks would be seen as a greater concern.[149] As regards the availability of experts, this is a more complex calculation. The analogy between expert witnesses and advocates ignores the fundamental differences between their roles. An advocate faced with the removal of immunity is less likely to leave legal practice, or be put off by the threat of being sued, than will a surveyor or paediatrician to abandon forensic work.[150] Experts have busy professional lives away from the legal system and can choose not to take on forensic work, while advocates have no such easy choice. There is concern that this decision might lead to a professional class of expert witness who would create fewer procedural problems but would lose the freshness and challenge to dogma that comes with diversity.[151]

3. Vexatious Claims

The minority (Lady Hale and Lord Hope) were concerned about the understandable but usually unjustifiable desire of a disappointed litigant to blame someone else for his lack of success in court. Given the lack of reliable evidence about what the effects of the abolition of the immunity might be, they preferred to leave any reform, if needed, to Parliament. As Lord Hope expressed it:

> [T]he lack of a secure and principled basis for removing the immunity from expert witnesses, the lack of a clear dividing line between what is to be affected by the removal and what is not, the uncertainties that this would cause and the

[148] For a critique of Lord Phillips' judgment see C Pamplin, 'Supreme Court Experts?' (2011) 161 *New Law Journal* 488.
[149] This was highlighted by *Meadow v General Medical Council* [2006] EWHC 146 (Admin).
[150] Following the *Meadow* (Ibid.) litigation, obtaining expert witness evidence from paediatricians in child abuse cases has become problematic. Karen-Paz (n 130), endnote 50.
[151] Pamplin (n 148) at 489.

> lack of reliable evidence to indicate what the effects may be suggest that the wiser course would be to leave matters as they stand.[152]

The issue of potential satellite litigation remains an open one. Nevertheless, with this judgment, the Supreme Court has abolished an expert's immunity from suit concerning breaches of duty, whether in contract or tort, in connection with their participation in legal proceedings. An expert can now be sued for negligence concerning pre-trial work intimately connected with the case, his oral evidence in court, the contents of a report adopted in evidence and concessions made in experts' meeting or a joint statement.

4. Access to Justice

> Immunity is a very unforgiving defence. It leaves the victim of even the most serious negligence without any remedy. Why should the expert who provides advice to a client, and receives payment for that service, be free from claims if their view is negligent? After all, they are doing no more than a solicitor or barrister advising as to the merits of the case.[153]

I would argue that the most compelling argument for abolishing the immunity from suit of expert witnesses is the general rule that 'where there is a wrong there should be a remedy' which is a cornerstone of any system of justice. In fact, to deny a remedy to the victim of a wrong, therefore, should always be regarded as exceptional.[154] In the end, the majority of the Supreme Court concluded that this principle trumped the pragmatic issues of the need for insurance, rising costs, competing duties, potential availability of expert witnesses and the threat of satellite litigation. Access to justice for litigants who have a claim against a negligent expert has now been assured. However, on a final dispiriting note, the abolition of legal aid for clinical negligence cases[155] means that, except for 'cherry-picked cases', it will be difficult for claimants to afford expert witness advice, which is the linchpin of clinical negligence cases. The use of expert evidence is one way that the court defines the requisite standard of care owed to the patient. Another, or additional method, is by the use of guidelines.

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[152] *Jones v Kaney* (n 14) at 173.
[153] Hardiman (n 145).
[154] Lord Dyson at 113.
[155] Part 1 Legal Aid, Sentencing and Punishment of Offenders Act 2010–2012. The Government has withdrawn legal aid from clinical negligence cases. See Chapter 3 'Funding Litigation' above.

C. The Expert Witness: The Role of Protocols and Guidelines

Several cumulative pressures have fuelled the need for transparent accountability of clinical judgement. The finding of the Bristol Inquiry shook public confidence and called into question standards within the NHS.[156] The fifth report of the Shipman Inquiry highlighted that it is not sufficient for guidance to be implicit in the context and circumstances of clinical practice.[157] The lack of explicit standards can result in inconsistent and widely varying decisions, as well as tragic consequences for patients and their families. In recent years, there has emerged the concept of evidence-based medicine and the development of clinical practice guidelines which reflect this evidence.[158] Among the tools that inform the expert's base of knowledge are the guidelines of the medical colleges, teachers, textbooks, refereed journal articles and personal experience.[159]

Guidelines are consensus statements developed to assist clinicians in making decisions about treatment for specific conditions. They are developed systematically on the basis of evidence and aim to promote effectiveness and efficiency of healthcare delivery. In England, the NHSLA operates a Clinical Negligence Scheme for Trusts (hereinafter 'CNST'), which sets its own approved risk management standards, against which healthcare providers are assessed. The CNST operates as a quasi-insurance system for NHS Trusts, so there are obvious economic incentives for Trusts to ensure compliance with the NHSLA risk management standards. In addition, the Royal Colleges of Medicine routinely issue best practice guidance and the National Institute of Health and Clinical Excellence (hereinafter 'NICE') has developed cost-effective treatment protocols for a number of conditions. Although beyond the scope of the thesis, I would raise the question of how far financial constraints affecting resources in the NHS should dictate the court-accepted appropriate institutional standard of care.[160] Given the wealth

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[156] *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–95* (Cmnd. 5207 2001).
[157] *Safeguarding Patients: Lessons Learned from Past – Proposals for the Future*, 5th Report (Cmnd. 6394 2004).
[158] R Rosen and S Dewar, 'On Being a Doctor. Redefining Medical Professionalism for Better Patient Care' King's Fund (2004). S 46 of Health & Social Care (Community Health & Standards) Act 2003 sets out the legislative basis for health and care standards. See generally A Samanta 'The Role of Clinical Guidelines in Medical Negligence Litigation: A Shift from The *Bolam* Standard?' (2006) 14 *Medical Law Review* 321 and Brazier and Cave (n 62) p 167, fn 62 therein.
[159] Merry and McCall Smith (n 121) at 185.
[160] See Beswick (n 15) for a fuller discussion.

of evidence of best practice which now exists, courts increasingly rely on professional guidance when determining the standard of care.[161] The considered judgement of NICE, or the profession itself, will be evidence of what constitutes responsible practice but need not be dispositive. Where departure from the guidelines can be justified in the interests of the patient, the doctor discharges his duty of care.[162] In the previous discussion regarding the *Bolam* and *Bolitho* tests of the standard of care, the former relies on the medical interpretation of a reasonable standard of practice, while the latter sanctions the courts to challenge medical evidence where appropriate. Explicit guidelines assist the court in so doing.[163]

VII. CONCLUSION: THE CLAIMANT'S BURDEN – DUTY and BREACH

While the scope of the duty of care reflects the boundaries of liability, the standard of care determines the level of care a patient may reasonably expect. I have noted my reflections on how access to justice is affected by the legal rules pertaining to the existence of a duty of care. I have discussed how the courts use the *Bolam* and *Bolitho* tests for establishing when there has been a breach of that duty and how the requisite standard of care is identified by expert witnesses using *inter alia* professional and Government guidelines. I analysed how the historic *Bolam* test could be construed as doctors, through their expert witnesses' testimony, being judge in their own case. *Bolitho* heralded a new dawn for claimants, giving courts the ability to analyse medical practice and make sure it stood up to logical examination. However, we have also seen that, post-*Bolitho*, judges are not empowered to decide themselves what constitutes good medical practice but may require expert witnesses to justify and explain the basis of their judgements. Although the *Bolitho* criteria are not frequently triggered, their existence assists claimants in their need to prove breach of duty. I have noted the recent development of the removal of immunity from suit for expert witnesses. This assists

[161] Jackson (n 45) at 121. See narrative verdict of Dr Shirley Radcliffe, Coroner, who expressed 'grave concern' at the Inquest of Suzanne Ballantyne, 47, who was given 800 micrograms of misoprostol at St George's Hospital in Tooting to bring on delivery after her baby died in the womb. Mrs Ballantyne suffered multiple ruptures to her womb, causing vital organs to fail. No scientific evidence was presented for using 800 micrograms. Four days previously, the Royal College of Obstetricians and Gynaecologists had recommend doses no higher than 50 micrograms – though at the time of Mrs Ballantyne's death there were no official guidelines from the Government's drug rationing watchdog NICE. *Evening Standard* 3 June 2011.

[162] Brazier and Cave (n 60) at 191. See also Merry and McCall Smith (n 121) Chapter 6 for a more nuanced discussion of the interpretation of guidelines.

[163] Brazier and Miola (n 83).

claimants to call their expert witnesses to account where necessary. The proposed removal of legal aid to fund most clinical negligence cases is a retrograde step and acts against access to justice for claimants.

My remit has been to consider these issues in the light of litigation for redress for iatrogenic harm occasioned within the NHS. Although throughout its history, the NHS has been needs-led and short of resources, there is presently an acute national financial crisis which means that decisions, for example regarding funding cases and resource allocation, have been overtly finance-led rather than principled.

As noted, establishing the existence of a duty of care in the medical setting is normally not problematic but the question of whether hospitals have a non-delegable duty of care remains open and will be of increasing relevance.[164] The HRA 1998, while having a limited impact on the way the courts deal with medical negligence, has changed the mindset of patients who now speak in terms of rights rather than gratitude. A remaining troubling issue is the level at which judicial determination of the requisite standard of care will rest. Will there be a point where the court does not countenance a lack of resources?[165] The withdrawal of immunity from suit for expert witnesses is less troublesome than the withdrawal of legal aid for their fees which will mean that meretricious but uncertain clinical negligence cases will not be undertaken. The potential for the court to be the final arbiter of breach of duty after *Bolitho* is to be welcomed, although this power is to be used sparingly. Assuming a patient/claimant has fulfilled his obligation of proving he was owed a duty of care and that the doctor breached his duty, he must then prove that the breach caused his damage. In the next chapter I consider the major hurdle of proving causation.

[164] R Nayer, 'Outsourcing Genetic and Diagnostic Services: A Consideration of the Principles for Establishing Delegable Duty and Why it Matters' (2011) 2 *Journal of Personal Injury Law,* 61–70.
[165] Beswick (n 15).

CHAPTER 5

PROVING LIABILITY

CAUSATION

It is a tenet of epidemiology that association is not synonymous with causation. Unfortunately, the distinction between association and causation is frequently overlooked, and novel epidemiological findings are often referred to, particularly in the non-scientific press, as demonstrating a 'link' between an exposure and some adverse health outcome, inviting the erroneous conclusion that a cause-and-effect relationship has been established. This confusion of association with causation can have important ramifications for policy decisions, compensation claims and the attitude of the general public towards epidemiology and other statistical sciences[1].

Academic writers have suggested that in cases of clinical negligence, the need to prove causation is too restrictive of liability.[2]

[1] R Wakeford, 'Association and Causation' (December 1994) *RSS News*.
[2] Lord Hoffmann, *Gregg v Scott* [2005] UKHL 2, hereinafter *Gregg*, paragraph 84.

I. INTRODUCTION

The true battleground in many clinical negligence cases is not breach of duty at all but the vexed question of causation.[3] Clinical negligence cases, unless they arise out of elective cosmetic surgery or family planning, involve claimants who, by definition, were ill or injured before the treatment was given or sought and, by the very nature of their complaint, are ill or injured at the end of the process. Demonstrating the causation of the particular injury or illness complained of to the requisite legal standard can be of the utmost medical and legal complexity.[4] Having addressed the issues of when a duty of care arises and whether there has been a breach of that duty, we now come to the most problematic aspect of a patient's claim. He must show that his injury, his worsened or unimproved condition, was caused by the doctor's negligence. Clinical negligence claims have special difficulties, not only because of the vagaries inherent in illness and treatment but also the differences between scientific and legal approaches to the problem of causation.

In order to put the problems in proving causation into context, I start this chapter with consideration of the special features of claims for clinical negligence, namely, medicine understood as an art, followed by a brief comparison between the scientific and legal approaches to evidence of causation. I will then present the legal approach to determining causation. Causation of primary injury at the liability stage may take a number of forms: classical causation; other forms of causal connection which do not depend on a comparison, such as 'material contribution'; and causation in the rare claims where the analysis of the causation of damage departs from a strict approach which would leave the claimant unable to prove damage.[5] These approaches address the question of whether the patient can convince the court that it was the relevant negligence which caused his injury, rather than the progress of his original disease or condition. Here, the court, in determining what did happen, is dealing with past fact, and decides on the balance of probabilities. Once a finding is made as to past fact, the finding is treated as certain, even though there is anything up to a 49% chance of it being incorrect.[6]

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[3] P Balen, *Clinical Negligence* (Bristol, Jordans Publishing Limited, 2008) 187.
[4] Ibid.
[5] See *Chester v Afshar* [2005] 1 AC 134 below.
[6] Balen, (n 3) 188.

There is another line of cases that addresses a different question. How should courts proceed when the essence of a claim is not that clinical negligence caused any fresh or additional injury to the patient, but that negligence deprived him of a chance of full recovery from his original disease or condition? These cases, known as loss of chance cases, are about future events.[7] For example, in *Greg v Scott*[8] the question to be addressed was whether the delay in diagnosis reduced Mr Gregg's chance of a 'cure' (defined as ten years in remission) from 42% to 25%.[9] In each and every case the patient must advance evidence showing that it is more likely than not that the defendant's negligence caused the injury of which he complains.

After I conclude the discussion of the legal approach to causation, essentially liability, I will address the topic of damages.

II. SPECIAL FEATURES OF CLAIMS FOR CLINICAL NEGLIGENCE

A. Medicine as an Art

Prior to focusing on the legal issues in establishing causation in clinical negligence cases, it might be helpful to consider the peculiar characteristics of what John Harrington describes as 'the art of medicine and the common law'.[10] According to Harrington, the notion of clinical practice as an art has been frequently deployed by commentators on medicine, as well as by leaders of the profession over the last two centuries.[11] The strategic value of the notion of clinical practice as an art has lain in its valorisation of an extensive zone of professional autonomy in the face of attempts to commercialise or bureaucratise the practice of medicine. Harrington goes on to ask the question: 'What is the characteristic target of medical intervention?' The reply is that 'the characteristic target of medical intervention is the individual case'.[12] This has interesting consequences.

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[7] M Brazier, and E Cave, *Medicine, Patients and The Law*, 5th edn (Harmondsworth, Penguin, 2011) 204.
[8] *Gregg* (n 2).
[9] The issue of a cure was the future event.
[10] J Harrington, 'Elective Affinities: The Art of Medicine and The Common Law' (2004) 55 *Northern Ireland Legal Quarterly* 3, 259-276.
[11] For example, ibid, 260, fn 2.
[12] Ibid, 260 fn 4 quotes: ED Pellegrino and DC Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York, Oxford University Press, 1981) 80 '...clinical medicine is guided by a telos of individuation'.

One of the most important attempts in recent decades to theorise the 'object domain of clinical medicine' was made by Samuel Gorovitz and Alasdair MacIntyre.[13] Their intervention was motivated by a practical concern with the so-called malpractice crisis that had beset American medicine since the 1960s. They identified three sources of medical mishaps. Firstly, the culpable errors of practitioners; secondly, the underdeveloped state of scientific knowledge; and thirdly, a source of error which had hitherto been overlooked, namely the unique complexity of each patient. Unlike physics or chemistry, which aim to establish law-like generalisations about universal phenomena, clinical medicine is a 'science of particulars'.[14] As such, the objects of medicine are, to use their example, more comparable to unique phenomena such as hurricanes, than to chemical compounds, atoms or sub-atomic particles. 'Particulars' are not intelligible *in abstracto*, but only through their distinctive histories and their evolving relations with the environment. Given their complexity, diversity and contingency, they cannot be adequately comprehended in law-like generalisations. In fact, any prediction regarding their future development, either with or without therapeutic intervention, is prone to a 'necessary fallibility'.[15] Put another way, each patient's case is a 'universe of one'.[16] A diagnosis may be incorrect or a therapy may fail regardless of the care taken by the practitioner and irrespective of all possible scientific knowledge. Hence, the third source of medical accidents is one which implies no culpability.[17] The cause of the injury or damage could be said to have been occasioned by the pre-existing or background conditions.

B. Difficulties of Proof of Causation in Medical Cases

Proof of causation in medical cases is especially difficult for patients and has been a subject of concern voiced on numerous occasions. The Pearson Report (Royal Commission on Civil Liability and Compensation for Personal Injury) in 1978 noted a proposal to reverse the onus of proof but agreed with the fear, often expressed in

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[13] S Gorovitz and A MacIntyre, 'Toward a Theory of Medical Fallibility' (1976) 1 *Journal of Medicine and Philosophy* 51 as quoted in Harrington (n 10) 261.

[14] As such, clinical medicine 'is in fact hardly commensurate with any customary notion of science' J Widder, 'The Fallibility of Medical Judgement as a Consequence of the Inexactness of Observations' (1998) 1 *Medicine, Health Care and Philosophy* 119.

[15] Gorovitz and MacIntyre (n 13) 62, as quoted in Harrington (n 10) 261.

[16] DA Schön, *The Reflective Practitioner. How Professionals Think in Action* (London, Temple Smith, 1983) 68.

[17] For debate and criticism see Harrington (n 10) 261. See also Professor JG Fleming, 'Probabilistic Causation In Tort Law' (1989) 68 *Canadian Bar Review* 661-681 at 662 regarding the difficulties with traditional methods of proving causation.

England, that it would increase claims, many of them groundless, and result in an increase of defensive medicine.[18] It has been suggested that the traditional test for the burden of proof of causation in tort, namely proof on a balance of probabilities, has come under challenge in dealing with non-traumatic injuries such as man-made diseases linked to chemical products like Thalidomide, DES and Agent Orange.[19]

In cases of clinical misadventure, medical science does not always enable us to prove why an injury risked occurs or does not occur during surgery. In that situation, the risk is called a random risk, but all that it really means is that it is beyond the control of the surgeon. The fact is that medical science cannot, in some cases, explain why an injury risk has happened. In those cases, all one has is historical evidence which shows that there is a statistical chance of injury in certain operations. In comparing, therefore, an actual operation performed on 21 November 1994 with a hypothetical one performed at some later date, all that is capable of proof is that the statistical chance of injury was the same in each case. What cannot be proved in relation to a purely hypothetical operation is that a statistical injury of, say, 0.9% would be more likely than not to have given rise to an actual injury.[20]

Another problematic group of cases are those involving medical procedures depriving patients of a chance of survival or a cure. Tony Fleming points to the same problem as that cited by Harrington,[21] namely, that it is difficult to prove medical causation by 'particularistic' evidence, that is, direct, anecdotal, non-statistical evidence from the mouth of witnesses. In a postscript to his initial paper, Fleming emphasises that:

> A frequent occasion in modern litigation is the inability of medical experts to explain the aetiology of an injury with a degree of exactitude and confidence postulated by traditional formulas like 'reasonable certitude' or 'reasonable probability'. The inherent limitations of medical knowledge, combined with a tendency of physicians

[18] Royal Commission on Civil Liability for Compensation for Personal Injury, Cmnd. 7054-1 (1978) paragraph 1336 (*The Pearson Report)* as quoted in Fleming Ibid. at 670. He cites German law which reverses the onus of proof against doctors guilty of gross error in treatment. He also cites the law in California (Evidence Code, s 646) which reverses the burden of producing evidence, though not the burden of proof. This rule is justified on the grounds of equity because the physician's very fault created the difficulty of proof. See also A Porat and A Stein 'Indeterminate Causation and Apportionment of Damages: An Essay on Allen Holtby and Fairchild' (2003) 23 *Oxford Journal of Legal Studies* 4, 667 at 701, whose 'evidential damage doctrine' would force defendants to compensate the claimant for the potential value of missing information of which the defendant wrongfully deprived the claimant.
[19] Ibid.
[20] See J Sher, 'The Triumph of Logic Over Common Sense? A Commentary on *Chester v Afshar*', (2002) 70 *Medico-Legal Journal* 4, 188-193; *Chester v Afshar* [2002] EWCA Civ 724; [2003] QB 356.
[21] Harrington (n 10).

> to express outcomes in terms of percentage, create problems of compatibility with legal standards, which are both linguistic and substantive.[22]

It has been noted that proving that the negligence caused the claimant's hurt is a formidable task for the claimant.[23] In medical negligence cases, these difficulties are often amplified for two reasons. Firstly, the aetiology of disease and injury is frequently difficult to establish even for experts. Secondly, patients are, by definition, usually ill and the doctor's negligence will usually relate to a failure to cure or alleviate their existing condition, requiring the court to ask the hypothetical question: 'What would have happened if there had been no negligence?'[24]

A case has been made that there are considerations specific to medical law which call for a treatment of causation beyond that which can be found in standard works on the law of torts. Causation in the context of medical law is fraught with difficulty, due both to the complexity of the factual circumstances themselves and to the complex nature of the law, when the principles come to be applied to the facts. [25]

The complicated and, to some extent, indeterminate nature of medical science means that the causal nexus between X and Y, while suspected, may be hard to demonstrate. Indeed, it could be said that the more medicine is portrayed as a scientific endeavour rather than as an art or a combination of both art and science,[26] the more difficult it becomes to demonstrate to the satisfaction of the law a causative link between breach and damage. As for the latter, the law becomes ever more complex as it seeks to serve the twin aims of justice: fairness to the patient and the doctor.[27]

In summary, in most non-medical tort cases proof of causal connection does not feature as a major problem. This is because, apart from the defendant's fault there is no other

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[22] Professor JG Fleming, 'Probabilistic Causation In Tort Law: A Postscript' (1991) 70 *Canadian Bar Review* 136 at 136.
[23] A Grubb, 'Problems of Medical Law' in S Deakin, A Johnston, and B Markesinis (eds), *Markesinis and Deakin's Tort Law* 5th edn. (Oxford, Oxford University Press, 2003) 244. This section is not in the 2008 edition. The Chapter in 5th edition written by Grubb is Chapter 3 Special Forms of Negligence. The next edition did not have this section on medical law.
[24] For an alternative where further conduct of the defendant (or someone else) would have been necessary to complete the causal chain see *Bolitho v City and Hackney HA* [1997] 39 BMLR 1 (HL).
[25] See Lord Bridge in *Hotson v East Berkshire AHA* [1987] 2 All ER 909 who remarked: 'In some cases, perhaps medical negligence cases, causation may be so shrouded in mystery that the courts can only measure statistical chances.'
[26] Echoing Harrington (n 10).
[27] I Kennedy, A Grubb, J Laing and J McHale, *Principles of Medical Law* 3rd edn (Oxford, Oxford University Press; 2010) 325.

relevant source of risk, whether defined in terms of physical or economic damage or in terms of a latent condition which would certainly, probably or possibly produce such damage in future. The background risk (B) of that past outcome, that is the sum of other sources of risk operating at the same time as the defendant's fault and which may have caused the outcome, was nil (B% = 0). What will be considered now are cases where the background risk is substantial.[28]

In clinical negligence cases, the background risk is usually substantial. In cases that manifest sufficient actionable damage in circumstances where the B% is substantial, although an 'outcome' has occurred – say, for example, that the claimant has contracted cancer – the claimant will be met with the argument that the outcome was caused by the B% and not by the actionable damage. In the traditional form of the causation issue, the claimant must prove on a balance of probabilities an actual causal link between the defendant's fault and the past damage forming the gist of his action. If the gist of the action is formulated in terms of outcome, this means that the claimant must show that the extra risk attributable to the defendant's fault (D %) is greater than B%, so that, more probably than not, the outcome was due to the former (D %) and not the latter (B %).[29] The application of the traditional balance of probability test in medical cases has two intrinsic drawbacks. The most obvious one is that the test does not work where estimates of the risks B% and D% are simply not available. The other problem is the 'all-or-nothing' nature of the test.[30]

In short, medical negligence cases involving therapeutic treatment present difficulties of multiple causation as a matter of routine. Two candidate conditions are automatically present: the patient's condition, which represents a deviation from the standard physical condition of human beings, and the doctor's breach of duty.[31]

[28] J Stapleton, 'The Gist of Negligence Part II' (1988) 104 *Law Quarterly Review* 389.
[29] Ibid.
[30] To be discussed in regard to 'Loss of Chance' cases below.
[31] M Stauch, 'Causation, Risk and Loss of Chance in Medical Negligence' (1997) 17 *Oxford J Legal Studies* 2, 205 at 213-4.

C. Science and Law Compared [32]

The civil courts increasingly have to apply legal principles to scientific evidence in respect of claims concerning medical products, environmental toxins and medical liability. It was noted that, when determinations are made regarding standard of care and breach of duty, medical expert evidence is crucial.[33] Difficulties arise from the very different traditions of reasoning between science and the law. Scientific data are collected and analysed by scientists in order that they can make assertions which are meaningful to scientists. The conflict arises when these data, analyses and assertions are considered as evidence by the court in order to make a legal determination. The major distinction between legal determinations and scientific assertions lies in the concept of certainty. The legal concept of causation is deterministic: it is an expression of the fiction of certainty, an absolute concept. The scientific concept of causation is probabilistic: it is an expression of the uncertainty of truth, an asymptotic concept.[34] Another way to consider the division is that science seeks truth, while the law does justice; science is descriptive, but law is prescriptive; science emphasises progress, whereas law emphasises process. These simplified characteristics restate in varying ways the insight that fact-finding in the law is always contingent on a particular vision and mechanism for delivering social justice. Scientific claims, by contrast, are thought to lack such contingency.[35]

I will now turn to the causal requirements for liability: the 'but-for' test; the doctrine of material contribution to the damage; material contribution to the risk of damage; the loss of chance cases; and the cases where the court has departed from the generally accepted rules. This last category, cases decided on the basis of policy rather than principle because the justice of the case appeared to require it, has resulted in uncertainty and 'judicial indiscipline'.[36] It is for the courts to devise the rules that determine causation. The result of the uncertainty created is that development and distortion of the common law appear indistinguishable, flexibility and uncertainty

[32] The ideas discussed in this section are based upon M Powers, NH Harris and A Barton, *Clinical Negligence* 4th edn (Haywards Heath, Tottel Publishing, 2008) ch 25 on Causation.
[33] Chapter 4 Proving Liability: Duty of Care and Breach of Duty above.
[34] Powers et al (n 32) ch 25. para 25.50.
[35] Ibid.
[36] See *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22 (hereinafter *Fairchild*); *Chester v Afshar* [2004] UKHL 41, hereafter *Chester*.

become conflated, and policy replaces principle. The determination of legal liability is a judicial function based on evidence, not belief, hope, wishful thinking or policy.[37]

III. THE CAUSATION ELEMENT

In the tort of negligence, damage is the gist of the action.[38] In order to succeed in a claim for clinical negligence, a claimant must show, on a balance of probabilities or 'more probable than not', that he sustained damage as a result of the defendant's breach of duty. No cause of action lies in a wrong which has not resulted in some element of loss, injury or damage of a kind which was reasonably foreseeable, for which the claimant can sue. The defendant is not liable for losses which were not wrongfully caused by him. So the claimant must prove that the defendant caused the loss for which he seeks compensation.[39] If the claimant cannot show this, there is no tort and the action fails. In contract, a claimant who proves that the defendant was in breach of contract is entitled to nominal damages, but again, he will not be awarded substantial damages unless he establishes a causal link between the breach and his loss. A similar principle applies to a claim in battery, which, as an action in trespass to the person, is actionable *per se*.[40]

Causation is concerned with the physical connection between the defendant's negligence and the claimant's damage. No matter how gross the defendant's negligence, he is not liable if, as a question of fact, his conduct did not cause the damage. Thus, there must be a causal link between the defendant's breach of duty and the damage sustained by the claimant.[41] This is essentially an explanatory inquiry: how, in fact, did the damage occur? In medical malpractice litigation, this issue is largely a matter of medical and scientific evidence, for example, about the pathology of a particular disease and the prospects for successful treatment with proper care. The question is normally dealt with by the 'but-for' test. It is, however, important to note that the original legal rules relating to causation, which are based on the 'fiction of certainty', are now giving

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[37] Ibid.
[38] M Jones, *Medical Negligence* 4th edn. (Andover, Sweet & Maxwell Ltd., 2008) 375. Per Lord Scarman in *Sidaway v Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 883H, in 'Loss of Chance' cases, the question becomes whether the lost chance can become the 'damage' and therefore the 'gist' of the tort.
[39] J Stapleton, 'Cause-in-Fact and the Scope of Liability for Consequence' (2003) 119 *Law Quarterly Review* 388, 389.
[40] Authority for this is Jones (n 38) 558.
[41] HLA Hart and A Honoré, *Causation in the Law* (Oxford, Oxford University Press, 1959 and 2nd edn 1985).

way to a more sophisticated, analytical approach as we have an increasing understanding of our lack of ability to be certain.[42] In recent decisions such as *Fairchild v Glenhaven Funeral Services*[43], *Gregg v Scott*[44] and *Chester v Afshar* (each of which is discussed below),[45] the judgments have been more explicit and open about being informed by policy and the language of rights rather than being bound by the strict rules of causal considerations.[46] In *Gregg v Scott*[47] (a loss of chance case discussed below), the question of whether the law demands proof of negligence on the balance of probabilities, that is over 50%, was discussed 'with great learning and intellectual honesty'[48] in the five speeches of the Law Lords. The ratio of *Gregg v Scott* is clear on one level: where a claimant has suffered a loss of chance of recovery as a result of medical negligence but the chance is less than even, he is not entitled to compensation for that lost chance. Nonetheless, there were 'blistering dissents' from Lords Nicholls and Hope, who felt that it was unfair to require that the claimant prove his case on a balance of probabilities when medicine is full of uncertainties.[49]

A. The 'But-For' Test

In the English law of tort, it is customary to analyse the question of causation in two stages.[50] The first, referred to as 'factual causation', 'cause-in-fact', or 'cause', is essentially concerned with whether the defendant's fault was a necessary condition of the loss occurring. This 'test' consists of posing the question: would the loss have been sustained but for the relevant act or omission of the defendant? If it would not, the defendant is normally absolved at this point. If, alternatively, the claimant is able to show, on the balance of probabilities, that he would not have suffered the harm in

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[42] J Matthews 'Uncertain Causation: Gregg v Scott' Lecture notes CPIL College Clinical Negligence Conference 7 and 8 October 2004.
[43] *Fairchild* (n 36); (n 131) per Lord Hoffmann at paragraph 52. 'The causal requirements for liability often vary...and since the causal requirements for liability are always a matter of law, these variations represent legal differences, driven by the recognition that the just solution to different kinds of cases may require different causation requirement rules.'
[44] *Gregg* (n 2).
[45] *Chester* (n 36).
[46] *Ibid.* Lord Hope of Craighead at paragraph 80: 'the courts have power in certain cases to override causal considerations in order to vindicate a plaintiff's rights...'.
[47] *Gregg* (n 2).
[48] Charles Foster, 'Last Chance for Lost Chances: *Gregg v Scott* in the House of Lords' (2005 18 Feb*) New Law Journal* 248.
[49] Ibid. Also see below in IV 'Loss of Chance'.
[50]See A Honoré, 'Causation and Remoteness of Damage', Chapter 7 in A Tunc (ed), *Int. Encl. Comp. L.* (Leiden, Martinus Nijhoff and Tubingen, Mohr Siebeck, 1983) xi, 67, referring to the similar 'bifurcation' of analysis in the American common law and in German law. Also Deakin et al (n 23) 244 'Causation of Damage'.

question, the defendant may still succeed by establishing the absence of what is called a 'legal cause'. At this second stage, the courts make an assessment of whether the link between the conduct and the ensuing loss was sufficiently close. In other words, judges decide which of the conditions of the claimant's harm should also be regarded in a legal sense to be its causes. Judges will also consider whether a particular event 'broke the chain of causation', and use such terms as 'direct', proximate', 'foreseeable' or (alternatively) 'remote', to describe the relation between an act or omission and its consequences.[51]

The separation of these two stages of inquiry, and the use of the terms 'factual' and 'legal' cause to describe them, is by no means free of controversy. One may question, for example, whether the issues, which come under the rubric of 'legal cause', really have very much to do with causation in the sense of describing the relations between particular events in time and space.[52] The courts appear to be using the language of cause to decide questions of policy, such as which of the parties is best placed to shift the loss in question (distributive justice), or which outcome will best promote loss prevention in that context in the future (deterrence).[53] The issue of insurability is also never far away.[54]

Notwithstanding that in actions for negligence, judges will consider all the elements discussed above,[55] it is unusual for it to be argued in a medical negligence case that the claimant's or some other person's conduct amounts to a *novus actus interveniens* or that his injury is too remote.[56] By contrast, factual causation is often an issue.[57]

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[51] A cause which does not pass one of these tests of (legally relevant) causal proximity may be termed a 'mere condition'. It is, in other words, a factor 'without which' the loss would not have been incurred, but it is a factor to which the law attaches no causal responsibility in terms of liability in damages.

[52] NJ Mullany, 'Common Sense Causation – An Australian View' (1992) 12 *Oxford Journal of Legal Studies* 3, 431.

[53] 'But the issues in question (proximate cause and remoteness) are not, according to causal minimalism, really either causal or factual and to treat them as such is to 'overload' the causal issue. They are rather issues of legal policy in disguise, better answered by asking whether, all things considered, the defendant should be held liable for the harm which ensued, or, on another view, whether the harm was foreseeable, within the risk, or within the scope of the rule violated by the defendant'. Hart and Honoré (n 41) xxxv Preface 2nd edn.

[54] Mullany (n 52) 431.

[55] Duty, Breach of Duty, Cause-in-Fact, Cause-in-Law, Damage, Proximity, *'novus actutus interveniens'* and Remoteness.

[56] Grubb in Deakin et al. (n 23) 257.

[57] Jones (n 38) 519. See *Barnett v Chelsea and Kensington Hospital* [1969] 1 QB 428 (failure to diagnose) where the court held that, even with a correct diagnosis, the plaintiff's condition was too far advanced for the hospital to have saved him.

A point about the 'but-for' test was made in *Bolitho v City and Hackney Health Authority,*[58] namely, that '[a] defendant cannot escape liability by saying that the damage would have occurred in any event because he would have committed some other breach of duty thereafter.'[59] This is simply saying that the court will seek to establish, as best it can, what would have happened but for the negligence, *both actual and hypothetical*, of the defendant.[60] *Bolitho* was essentially a case where causation depended on hypothetical human conduct. In *Bolitho* Lord Browne-Wilkinson concluded that there were two questions for the judge to decide on causation: (1) what would the doctor have done, or authorised to be done, if she had attended the claimant? and (2) if she would not have intubated, would that have been negligent? The *Bolam* test, not relevant to the first question, would be central to the second.[61] At the liability stage in a negligence claim for personal injury where 'but-for' causation is invoked,[62] it must be shown that it is more probable than not that the primary injury would have been avoided if the negligence had not occurred. The mere possibility of avoidance of injury is not enough.[63]

Once again, when thinking about what probability means, we come to the question of the relationship between science and law. Neither the claimant nor the court has to apply scientific standards of proof (statistical validity to 95% confidence level) when determining causation on the balance of probabilities and, moreover, the court should also be conscious of the possibility that an expert witness may have difficulty in readjusting his focus from the 95% confidence limit approach to the balance of probabilities test.[64]

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[58] *Bolitho v City and Hackney Health Authority* [1998] AC 232 discussed in Chapter 4 'Proving Liability: Breach of Duty' above.
[59] Ibid 240 (Lord Browne-Wilkinson).
[60] Grubb in Deakin et al (n 23) 234.
[61] Jones (n 38) 448.
[62] Where 'material contribution' type causation is invoked at the liability stage, it is usually because scientific knowledge does not permit an answer one way or another whether the negligence there would probably have been avoidance of the primary injury, or where a series of facts is too complex for such analysis. – *Bailey v MOD and Portsmouth Hospitals NHS Trust* [2007] EWHC 2913 (QB) J Foskett in P Balen (n 3) 188 (see below).
[63] *Gregg v Scott* [2005] 2 AC 176. (Hereafter *Gregg* AC).
[64] For discussion of the relationship between statistics used in epidemiology and the legal tests applied to determine causation questions when faced with scientific uncertainty, please refer to C Miller, 'Causation in Personal Injury: Legal or Epidemiological Common Sense?' (2006) 26 *Legal Studies* 4, 544, D Coggan, 'Causation and Attribution of Disease in Personal Injury Cases: A Scientific Perspective' (2009) 1 *Journal of Personal Injury Law* 12-19 and Jones (n 38) 455.

When considering proof of causation in an action for negligence, it is for the claimant to prove, on a balance of probabilities, that the defendant's breach of duty caused the damage.[65] So, where there are conflicting explanations for the claimant's condition neither of which is wholly satisfactory, the defendant does not have to prove that his explanation is the correct one, though failure to prove it may be a factor in deciding whether the claimant's explanation of the cause should be accepted. In some instances, the precise cause of the damage may be unknown, and this tends to be a particular problem with some types of medical injury, where the pathology of the patient's condition may be surrounded in mystery or be the subject of intense scientific dispute.[66] The 'but-for' test operates as a preliminary filter to exclude events which did not affect the outcome. It cannot, however, resolve all the problems of factual causation.

In sum, the basic rule of causation in tort is the 'but-for' rule, which requires that the claimant must show that, but for the defendant's breach of duty, he would probably not have suffered the injury complained of. In many cases, this rule does not give rise to difficulty. Problems arise, however, typically in cases where two or more factors have contributed to the adverse result in respect of which damages are claimed. These problems have led to modification of the 'but-for' rule in some circumstances and these will now be canvassed.

There are cases where there may be significant problems of causal uncertainty, in particular where, besides the risk posed by the defendant's faulty conduct, the claimant was exposed to other risks with the potential to cause the same harm. Here it may, after the event, be impossible for science to disentangle the different risks and say that absent the conduct of the defendant, the claimant would probably have avoided injury. In this regard, a long-standing issue is how far the doctrine of 'material contribution' may offer a legitimate alternative to the 'but-for' test, in permitting recovery on proof that the defendant's breach 'materially contributed to the harm' (without the need to go further and show it would not otherwise have occurred).[67] I will now discuss exceptions to the requirement to satisfy 'but-for' causation, namely, the alternative tests of material contribution to injury and material increase in risk of injury. There is an important caveat to bear in mind when discussing the case law. There are significant differences

[65] Note that the test for causation when considering a claim under Article 2 of the European Convention on Human Rights is not the same as that at common law. See Jones (n 38) 453.
[66] Ibid.
[67] M Stauch, '"Material Contribution" As A Response to Causal Uncertainty, Time for a Rethink' (2009) 68 *Cambridge Law Journal* 1, 27-30.

between industrial disease and medical negligence claims, justifying a more claimant-friendly approach in the former. There, typically, the claimant is exposed to risk factors that, even if the defendant is only at fault for one, all ultimately derive from the workplace environment. By contrast, in medical cases, the doctor intervenes on behalf of the patient to ward off natural risks (stemming from illness), and the treatment itself usually adds to the risks in play; furthermore (as noted by Lord Hoffman in *Fairchild*) in the case of NHS care, allowing recovery in doubtful causation cases will affect the resources available for other patients.[68]

The previous section of this chapter has discussed the 'but-for' test used to determine causation of damage, a necessary ingredient of a successful tort action. In the following section, I will discuss cases where there are 'evidential gaps' which the courts have tried to overcome in the interests of providing justice.[69] There will be a review of several cases where the courts have been prepared to draw inferences from the evidence to the claimants' advantage[70] and a medical case where they have not.[71] I will start by looking at the way in which the courts have approached problems of uncertain causation, namely: material contribution to the harm, material contribution to the risk of harm, a case of alternative causes and finally, the *Fairchild* approach to causation,[72] I will conclude with some thoughts on the significance of judicial 'leaps over evidential gaps' noting that, on the whole, these do not come into play in clinical negligence cases. The underlying question for present purposes remains that of what the claimant in a medical negligence case has to show to prove causation, in other words, evaluating how high the bar to liability is set and what exceptions the courts are prepared to make to ameliorate claimants' inability to show certain (probable) causation.

B. Uncertain Causation: Who gets the Benefit of the Doubt?

As noted, there may sometimes be significant problems of causal uncertainty in medical cases; in particular where – besides the risk posed by the defendant's faulty conduct –

[68] Ibid. Case comment *Bailey v Ministry of Defence* [2008] EWCA Civ 883.
[69] '...the reason why there were so many cases from Scotland in the 1950s and 1960s which appeared to be doing funny things about causation in industrial disease cases was that the judges were so aghast by conditions in the Scottish factories that they were determined to use tort law to get employers' liability insurers to do something about those conditions.' The Right Honourable Lord Justice Brooke, 'Patients, Doctors and The Law (1963-2003): (2004) 72 *Medico-Legal Journal* 72 Part 1, 17-30.
[70] *McGhee v National Coal Board* [1972] 3 All ER 1008 (hereinafter *McGhee*); *Fairchild* (n 36).
[71] *Wilsher v Essex AHA* [1988] AC 1074 (hereinafter *Wilsher*).
[72] To be discussed below.

the claimant was exposed to other risks with the potential to cause the same harm. In this regard, a long-standing issue is how far the doctrine of 'material contribution' may offer a legitimate alternative to the 'but-for' test in permitting recovery on proof that the defendant's breach 'materially contributed to the harm' without having to show that but for the defendant's breach it would not have occurred.[73]

In some instances, the precise cause of the damage may be unknown, and this tends to be a particular problem with some types of medical injury, where the pathology of the patient's condition may be surrounded in mystery or be the subject of intense scientific dispute. The Pearson Commission reported that: 'The Medical Research Council said that, while future research was likely to establish more causal relationships, it would also reveal increasingly complex causation in the individual case.'[74]

Faced with this kind of factual uncertainty, the claimant may have an impossible burden proving causation on the balance of probabilities, although it should be remembered that the claimant does not have to achieve scientific standards of proof.[75] Even where it is possible in principle to establish a connection between the type of harm suffered by the claimant and a specific hazard, it may be very difficult to show that the individual claimant's condition was *caused* by exposure to that hazard rather than some other factor for which the defendant was not responsible.[76] In such circumstances, where the scientific evidence is equivocal, the crucial issue from the claimant's point of view is whether the court will be prepared to draw an appropriate inference that there must have been some causal connection, since proof of causation in the medical sphere rests inevitably on the drawing of an inference of fact. The burden of proof is, therefore, ultimately a burden of persuading the court to attribute legal responsibility for the claimant's injuries to the defendant. This is patent in the case of causation in law, where the court must select from a number of causative factors the event or events that it considers to have been decisive. This is also the position, although maybe less obviously so, with the proof of causation in fact. The readiness of the court to draw an inference of fact, assisted where appropriate by principles of law, depends to some

[73] Stauch (n 67). Case comment *Bailey* (n 68).
[74] Royal Commission (n 18) paragraphs 1364-1449 'as the boundary of knowledge increases, so does the area of uncertainty'.
[75] Jones (n 38) ch 5 'Causation', 460.
[76] Ibid.

extent on the court's subjective assessment of the evidence which, in turn, may be influenced by the underlying policy objectives of the law.[77]

The starting point for the discussion of the doctrine of material contribution is to note that difficulties arise where there are several alternative explanations of the events leading up to the damage, some innocent and some traceable to the defendant's fault. The doctrine of material contribution evolved in the 1950s and reached its high point in the 1970s. The doctrine evolved around two House of Lords' cases concerning occupational diseases due to industrial dusts; the earlier case concerned pneumoconiosis due to silica dust[78] and the later one concerned dermatitis due to brick dust.[79] In each case, there was a single aetiological factor, either silica dust or brick dust. In both cases, as a matter of law, the dust came from two sources, one 'innocent' (not in breach of regulation or negligence) and one 'guilty' (in breach of regulation or negligence). In the first case, the exposure to dust sources was concurrent; in the latter case, the exposure to the dust sources consisted of consecutive episodes. In both cases, the claimant was unable to establish that, had there been no breach of duty, he would not have sustained any injury. In short, he was unable to satisfy the 'but-for' test.[80] It was with these cases that the doctrine of material contribution both to the harm and to the risk of harm evolved. This will be discussed below.

1. Material Contribution to the *Damage*: A Response to Causal Uncertainty?

The courts have gone some way to relieving a claimant of the rigours of the 'but-for' test where the difficulty of establishing causation has been a product of scientific uncertainty. In *Bonnington Casting Ltd v Wardlaw*,[81] the House of Lords held that the claimant does not have to establish that the defendant's breach of duty was the main cause of the damage, provided that it materially contributed to the damage.

[77] Ibid. Chapter 3 Standard of Care at 252. Where the issue is whether the claimant's medical condition would or would not have deteriorated with appropriate treatment it is not appropriate to import the *Bolam* test. Thus, where the judge is required to make a finding of fact in a case where there is conflicting expert evidence, the judge is entitled to prefer one group of experts over another. *Penney, Palmer and Cannon v East Kent Health Authority* [2000] Lloyd's Rep. Med. 41, 46, CA.
[78] *Bonnington Castings v Wardlaw* [1956] AC 613 (Hereinafter *Bonnington*) discussed below.
[79] *McGhee* (n 70) discussed below.
[80] Powers et al (n 32) ch 25 at para 25.11.
[81] *Bonnington* (n 78) a case of exposure to concurrent sources of harm.

As noted above, the claimant contracted pneumoconiosis from inhaling air which contained silica dust at his workplace. The main source of the dust was from pneumatic hammers for which the employers were not in breach of duty ('the innocent dust'). Some of the dust (the 'guilty dust') came from swing grinders for which they were responsible by failing to maintain the dust extraction equipment. There was no evidence as to the proportions of innocent dust and guilty dust inhaled by the claimant. Indeed, such evidence as there was indicated that much the greater proportion came from the innocent source. On the evidence, the claimant could not prove 'but-for' causation, in the sense that it was more probable than not that had the dust extraction equipment worked efficiently he would not have contracted the disease. Nonetheless, the House of Lords drew an inference of fact that the guilty dust was a contributory cause, holding the employers liable for the full extent of the loss. The claimant thus did not have to prove that the guilty dust was the sole or even the most substantial cause if he could show, on a balance of probabilities, the burden of proof remaining with the claimant, that the guilty dust had materially contributed to the disease. This case, followed by others,[82] was significant in easing the claimant's burden of proof for two reasons. Firstly, they were a departure from 'but-for' causation – the claimant did not have to prove that he would not have suffered the 'damage' (that is, the injury or illness) but for the breach of duty. What had to be proved was redefined as a 'material contribution' to the injury or illness. Notwithstanding this redefinition of the 'damage' to which the claimant must establish a causal link, the claimant still recovered damages for the whole loss, that is, the outcome, having proved causation in respect of a part only of that loss.[83]

The courts were willing to draw an *inference*[84] of fact that there had been a material contribution when it was, in reality, impossible to say whether there had been any such contribution, or even to make a statistical guess. Anything which did not fall within the principle *de minimus non curat lex* would constitute a material contribution. The long-standing issue of how far the doctrine of 'material contribution' may offer a legitimate

[82] Jones (n 38) ch 5, 460.
[83] J Stapleton, 'The Gist of Negligence: Part II' (1988) 104 *Law Quarterly Review* 389, 404-405. See now, however, *Holtby v Brigham & Cowan (Hull) Ltd.* [2002] 3 All ER. 421, paragraph 5-042. The subject of apportionment will be discussed in the subsequent chapter on damages. See Stapleton, 'Lords A Leaping Evidentiary Gaps' (2002) 10 *Tort Law Journal* 276, 283 for discussion of 'The question for the law in such cases (cumulative diseases) is whether there is a medical basis for apportionment of the cumulative condition'.
[84] Lord Wilberforce in *McGhee* (n 70) explicitly recognised that treating a 'material increase in the risk' as equivalent to 'a material contribution to the damage' involves overcoming an 'evidential gap' by drawing an inference of fact which, strictly speaking, the evidence does not support (as was done in *Bonnington*) this 'fictional inference is drawn for policy reasons'**.** Jones (n 38) ch 5, 460.

alternative to the 'but-for' test, in permitting recovery on proof that the defendant's breach 'materially contributed' to the harm, was addressed recently in the Court of Appeal's decision in the medical negligence case of *Bailey v Ministry of Defence.*[85]

In *Bailey*, the claimant underwent an operation for a suspected gallstone at a hospital run by the Ministry of Defence.[86] Complications, including extensive bleeding, occurred, but afterwards she was returned to the ward and received little aftercare. Subsequently, her condition deteriorated, due both to continued bleeding and the development of pancreatitis. After transfer to the intensive care unit and subsequent discharge from it, she became nauseous and vomited after drinking lemonade. Because of her weakened state she was unable to clear her air passages and choked. By the time she was resuscitated she had suffered brain damage.

At trial, it was acknowledged that the post-operative care had been negligent. The problem was causation. As noted, the immediate cause of the choking was her generally weakened condition. Nonetheless, this was contributed to not only by the inadequate aftercare, but by pancreatitis – a matter for which the defendant was not at fault. At trial, the experts were unable to say that but for the negligent care, she would probably have avoided the final catastrophe. The pancreatitis alone might have resulted in the same outcome. In response, the Court of Appeal (upholding Foskett J) held that the claimant was nevertheless entitled to damages. Waller LJ, who gave the only judgment,[87] categorised the case as one of 'cumulative risk exposure', in which the claimant was exposed to two sources of risk – inadequate aftercare, and pancreatitis – which combined to produce the harm. His Lordship followed dicta from Lord Rodger's speech in *Fairchild* which saw the decision in *Bonnington* as relaxing 'but-for' causation in favour of a test of 'material contribution'. The latter permitted recovery where medical science cannot establish the probability that but for an act of negligence the injury would not have happened, but can establish that the contribution of the negligent cause was more than negligible.[88] In contrast, His Lordship[89] distinguished *Wilsher* (discussed below),[90] where the House of Lords had required 'but-for' causation, on the basis that it involved 'alternative' sources of risk, operating mutually exclusively.

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[85] *Bailey* (n 68).
[86] For details and critique of the decision see Stauch (n 67). Case comment *Bailey* (n 68).
[87] Sedley and L Smith JJ concurring.
[88] *Fairchild* (n 36) 46.
[89] *Bailey* (n 68) at 44.
[90] *Wilsher* (n 71) discussed below.

In the judgment, Waller LJ disclaimed any suggestion that 'policy factors' favoured the finding of liability in industrial cases, such as *Bonnington* and *Fairchild*, while denying it in medical ones such as *Wilsher*. He asserted that: 'In my view one cannot draw a distinction between medical negligence cases and others'. Marc Stauch[91] is critical of the decision in *Bailey*, finding it potentially too claimant-friendly at the expense of the NHS. He finds the distinctions between 'cumulative' and 'alternative' risks arcane when, in both cases, the underlying problem is identical – the impossibility of establishing that the defendant's breach was necessary for the harm. He is disappointed that the court failed explicitly to deal with policy concerns, namely, the significant differences between industrial diseases and medical negligence claims, justifying a more claimant-friendly approach in the former. As noted earlier, whereas in industrial cases the claimant is exposed to risk factors that derive from the workplace, by contrast, in medical cases, the doctor intervenes on behalf of the patient to ward off natural risks occurring from the illness. This is compounded by the fact that the treatment itself adds to the risks in play. Stauch submits that the Court of Appeal's approach to resolving *Bailey* is unsustainable because of what it would mean for medical resource distribution. This discussion then brings to the fore the very issue with which my thesis is grappling, namely, that allowing recovery in doubtful cases will affect the resources available for other patients.[92] I, however, do not fear that the courts will be overgenerous to patient-claimants. I now turn to the issue of material contribution to the risk of harm.

2. Material Contribution to the *Risk of Harm*

> A benevolent principle smiles on these factual uncertainties and melts them away.[93]

Difficulties arise where there are several cumulative explanations of the events leading up to the damage, some innocent and some traceable to the defendant's fault. In *McGhee v National Coal Board*,[94] the pursuer, who had contracted dermatitis after working in the hot and dusty ambience of the defender's brickworks, alleged that the defender had materially increased the risk by not installing showering facilities. The defender conceded that it had breached the duty of care that it owed to the pursuer, but

[91] Stauch (n 67). Case comment *Bailey* (n 68).
[92] Per Lord Hoffman in *Fairchild* (n 36).
[93] *Fitzgerald v Lane* [1987] All ER 455, per Nourse LJ at 464.
[94] *McGhee* (n 70).

contended that in view of the inadequate medical knowledge about the causes of dermatitis, the pursuer had not proved on a balance of probabilities that he would not have contracted the disease, even if the washing facilities were present. The court found for the pursuer, invoking 'the practical way in which the ordinary man's mind works in the every-day affairs of life.'[95]

The House of Lords allowed the appeal of the pursuer from decisions of the lower courts in favour of the defendant. The judgment of Lord Wilberforce appears to accept the possibility that, in the absence of conclusive proof of a link between fault and damage, liability may be imposed upon a defendant whose negligence increases the risk of a particular loss occurring, if that risk is subsequently realised. 'It is a sound principle', he said, 'that where a person has, by breach of a duty of care, created a risk, and injury occurs within that area of risk, the loss should be borne by him unless he shows that it had some other cause'.[96]

Lord Wilberforce explicitly recognised that this line of reasoning involves overcoming an 'evidential gap' by drawing an inference of fact which, strictly speaking, the evidence does not support (as was done in *Bonnington*), and moreover that this 'fictional' inference is drawn for policy reasons. His Lordship went on to say:

> The potential in this line of reasoning for reversing the burden of proof of causation was enormous – the claimant does not have to show that the defendant's breach of duty caused his injury, merely that it increased the risk of injury. The basis for shifting the burden of proof on to the defendant is the inherent difficulty facing the claimant in a case where medical opinion cannot establish definitively that the damage is attributable to one potential cause of harm rather than another. Another rationale for reversing the burden of proof is that the defendant's admitted fault may be the very reason the claimant cannot prove his case on the balance of probabilities.[97]

The House of Lords, when reversing the decision of the Court of Appeal in *Wilsher v Essex Area Health Authority*,[98] held that *McGhee v National Coal Board*[99] did not have the effect of reversing the burden of proof. The burden of proof remains with the

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[95] Per Lord Reid Ibid at 1011. See E Weinrib, 'A Step Forward on Factual Causation' (1973) 38 *Modern Law Review* 518 for the role of value and judicial policy in determining what legal consequences the law should attach to the defendant's conduct.
[96] Lord Wilberforce referring to *McGhee v National Coal Board* [1973] 1 WLR 1 at 16.
[97] See Fleming (n 17) 671, discussing the use of this idea in Germany.
[98] *Wilsher* (n 71) discussed below.
[99] *McGhee v National Coal Board* (n 70)

claimant throughout, and he must establish that the breach of duty was at least a material contributory cause of the harm, applying *Bonnington*.[100]

Nevertheless, there is a problem in making the defendant liable for damage which, 'on the normal application of the "but-for" test, it cannot be proved he personally caused'.[101] According to Jane Stapleton 'if no medical basis for apportionment had been available when *Bonnington*[102] was argued, then, to the extent that the plaintiff recovered for the degree of pneumoconiosis that would not have occurred but for the inhalation of non-tortiously produced dust, the result in that case would represent the first in the line of cases leading to the *material contribution to risk* principle, allowing certain claimants to jump an evidentiary gap which emerged as the *McGhee/Fairchild* principle.'[103] The mere fact that a defendant was at fault, in the sense of breaching a duty of care, is not in itself a good enough reason for imposing liability. To do so may be to impose a powerful incentive for careful behaviour on the part of defendants (deterrence). But this runs up against the objection that it is not the role of the tort of negligence to penalise careless behaviour as such. Stapleton suggests that if this is seen as desirable, it can be achieved by Parliament through statutory regulation.

There are historical reasons for the court adopting a policy in limited circumstances of allowing the claimant to succeed when he was unable to demonstrate that the injury was avoidable. However, the courts have gone further and have equated an increased risk of injury with material contribution. The doctrine of material contribution is, of course, based not on principle but on policy. It is a fiction which enables claimants to succeed for policy considerations in certain circumscribed circumstances where the state of scientific knowledge is such that the cause and extent of their injury are unknowable.[104]

What later became known as the *McGhee/Fairchild* principle specifies the circumstances in which a claimant can 'leap an evidentiary gap' and secure damages against a defendant who increases the 'risk' of an injury which then arises. The language of risk is employed because uncertainty in the evidence prevents an identification of the precise causal connection – between the negligent act or omission

[100] *Bonnington* (n 78).
[101] Stapleton (n 28) 404.
[102] *Bonnington* (n 78).
[103] This is because the claimant in *Bonnington* (n 78) recovered entirely at trial even though he had not proven that the entire injury had been the result of the defendant. Stapleton (2nd ref n 83) 276.
[104] Powers et al (n 32) ch 25, para 25.21.

and the eventuated injury – which the common law has traditionally required. It is helpful to concentrate on two of Stapleton's six characteristics[105] which point to cases appropriate for the *Fairchild* exception, namely, the (substantial) similarity of the two or more agents of risk and the extent to which the sources of risk are under the control of the defendants. In *McGhee*, both conditions were met. The dust encountered non-negligently during the work shift and the dust which, through the employer's negligent omission to provide showers, remained upon claimant McGhee's skin, were identical and were both under the control of his employer.[106]

The difficulty in cases such as *Fairchild* is that, given the current state of scientific knowledge about the way in which asbestos fibres cause mesothelioma, an employee cannot satisfy the 'but-for' test if he has been negligently exposed to asbestos by different employers at different times during his working life. While he might be able to prove that at each workplace each employer failed in his duty of care to protect him from exposure, he will not be able to identify at which workplace the crucial exposure took place. His claim would fail.

Therefore, the proper application of traditional rules for determining causation, namely, the 'but-for' test and the doctrine of material contribution, does not entitle the claimant to compensation where the claimant has contracted mesothelioma as a result of wrongful exposure to asbestos from several previous employments. However, in *Fairchild*, after detailed review of the authorities, the court decided that the creation of a material risk satisfied the causal requirement for liability, or that exposure to a risk was equivalent to the making of a material contribution.[107] The Law Lords allowed the claim, holding all the defendant employers liable, as each of them had materially increased the risk of harm to their employees. Subsequently, in *Barker v Corus UK Ltd*

[105] Stapleton (2nd ref n 83) 281, 300-301. The *Fairchild* exception should apply in cases where: (i) an employee was employed at different times over differing periods by employer A and employer B; and (ii) employer A and B were both subject to a duty to take reasonable care to prevent the employee inhaling asbestos dust because of the known risk that it might cause a mesothelioma; and (iii) both employers A and B were in breach of that duty, with the result that, during both periods, the employee inhaled excessive quantities of asbestos dust and (iv) the employee developed mesothelioma and (v) any cause of the mesothelioma other than the inhalation of asbestos dust at work could be effectively discounted; but (vi) the employee could not prove, on the balance of probabilities, that his mesothelioma was the result of his inhaling asbestos dust during his employment by one particular employer or the other, or during both employments taken together. *Fairchild* (n 36) as per Lord Bingham.

[106] C Miller, 'Liability For Negligently Increased Risk: The Repercussions Of *Barker v Corus UK (Plc)*' (2009) 8 *Law, Probability & Risk* 1, 39-54 at 53 and 54 for arguments against so narrowly limiting risk liability.

[107] Powers et al (n 32) ch 25, para 25.23.

(PLC)[108] the Law Lords ruled that each defendant should be liable only to the extent of their relevant contribution to the claimant's exposure to asbestos dust. In the specific context of claims for contracted mesothelioma, Section 3 of the Compensation Act 2006 nullified that decision.[109]

We see then, that the 'but-for' test is conveniently applied where the conduct complained of consists of a discrete, identifiable act, whereas the doctrine of material contribution is conveniently applied where there are repeated acts or exposures against a background of non-tortious acts or exposure.[110]

The orthodox 'material contribution' doctrine is simple and should be uncontroversial, namely, 'the fact that, in addition to the tortious conduct of the defendant, other factors also materially contributed to C's[111] total state at trial is not a bar to C's claim*'*. There are two different ways in which a factor might 'materially contribute' to C's total state at trial: one situation is where C's state at trial is indivisible.[112] For example, in *Bonnington*, the House of Lords held that the claimant could recover in full. In that case, no attempt was made to persuade the court that the claimant should recover only for that part of his injury which could be attributed to the employer's negligence. Both sides went for all or nothing. No expert evidence was called to assess the contribution which the negligent exposure had made to the total. The injury was treated as indivisible.[113] The defendant cannot escape liability by pointing out that it was not the only agency responsible for the claimant's state at trial. A separate issue is that of the extent of responsibility. Since each tortfeasor historically connected to an indivisible injury has materially contributed to all of it, the orthodox rule is that each is liable in *solidium* to the claimant for the entire injury. The other situation is where C's state at trial is divisible. An example would be where D's tortious conduct harmed C, but before trial, C was further harmed by the carelessness of a third party. The third party's intervention is not a bar to C's claim. The defendant cannot escape liability by pointing out that he was not responsible for part of the claimant's state at trial. The extent of that responsibility is a separate issue. Here, D only contributed materially to a part of the

[108] *Barker v Corus UK Ltd (PLC)* [2006] UKHL 20.
[109] Brazier and Cave (n 7) 202.
[110] Ibid.
[111] C represents claimant.
[112] Stapleton (2nd ref n 83) 283, also *Dorset Yacht Co Ltd v Home Office* [1970] AC 1004. In general, see dictum of Devlin LJ in *Dingle v Associated Newspapers Ltd* [1961] QB 162 at 188-9.
[113] J Smith, 'Causation – The Search for Principle' (2009) 2 *Journal of Personal Injury Law*, 101-113. According to Smith, today such an injury would be treated as divisible with apportionment of damages.

claimant's state at trial, so since a medical basis for division of the total injury is possible, D is entitled to assert that it is only liable to the claimant for that portion of the total state to which he is historically connected.[114]

To summarise, there are key features which apply to the acceptance of the 'material contribution' to harm approach to causation: first, there must be no alternative complete cause of the injury complained of as in *Wilsher*,[115] where the act of negligence led to the provision of excess inspired oxygen, which was only one of a number of alternative possible causes of the child's blindness and could not be said, necessarily, to have contributed to it.[116] Secondly, the implicated cause must contribute to the primary injury. Increased risk of the injury occurring in the event of breach is not sufficient except in defined and limited circumstances where the court finds the defendant liable for materially increasing the risk of the resultant primary injury. This is in contrast to finding the defendant causing or materially contributing to the primary injury itself, as set out in *Fairchild*.[117]

The courts have also had to deal with the question of the burden of proof and with whether the defendant may be liable, in the absence of conclusive proof under the 'but-for' test, for increasing the risk of particular damage occurring. This possibility has been raised in order to reduce the considerable odds against certain claimants establishing the necessary causal link in industrial injury and medical malpractice cases. However, in *Wilsher* the House of Lords reaffirmed the centrality of the 'but-for' test to issues of causation in negligence. These cases concerned with material contribution may be contrasted with *Wilsher v Essex Area Health Authority*,[118] a case of alternative causes, to which I now turn.

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[114] Ibid.
[115] Discussed below.
[116] See *Wilsher* (n 71) at 1090-1091 HL for a recent example where the claimant fell on the *Wilsher* side of the line: *Temple v South Manchester Health Authority* [2002] EWCA Civ 1406, paragraphs 53-55. For further discussion see Balen (n 3) 198. For discussion of apportionment, see Smith (n 113) 101. The key principles of causation and personal injury are set out. This is followed by relevant case law examples where the basic but-for test has been modified to deal with apportionment in the case of divisible injuries and circumstances where due to a lack of scientific understanding a claimant can only establish that there has been a material contribution to the risk of injury as opposed to the injury itself.
[117] Ibid at 199 footnote 27.
[118] *Wilsher* [1998] 1 All ER 871 see below for discussion of *Wilsher* (n 71). *Wilsher* has once again been approved in *Fairchild* (n 36) and is still considered good law in medical cases, see below.

3. A Case of Alternative Causes: *Wilsher v Essex Area Health Authority*[119]

In this case, there were five, dissimilar, possible causes of the claimant's blindness; four stemmed from hazards inherent in premature birth and it was a failure to adequately regulate the air supply that constituted the (medical negligence) fifth. It was not possible to ascertain which of these five possible causes was actually responsible, even though the tort could be interpreted as increasing the risk of an injury which did indeed eventuate. However the 'shape' of this increased risk was not the shape which the *Fairchild* exception has subsequently come to recognise.[120] At the trial of the claimant's action for negligence, the medical evidence was inconclusive as to the cause of the claimant's condition. The House of Lords, reversing the Court of Appeal, held that causation had not adequately been established: 'a failure to take preventative measures against one out of five possible causes is not evidence as to which of those five causes caused the injury'.[121]

The question in *Wilsher* became whether, in a case of uncertain causation, it would be sufficient to show increased risk of harm as in *McGhee.* It was not possible to ascertain which of the five possible causes was actually responsible for the claimant's blindness. Although the tort could be interpreted as increasing the risk of the injury which did eventuate, the increased risk did not conform to the requirements for the *McGhee/Fairchild* exception.

The claimant, Martin Wilsher, was a premature baby who, through the defendants' negligence, received an excessive concentration of oxygen. It was known that excessive oxygen can damage the retina of a premature baby, leading to a condition called retrolental fibroplasia (RLF) which results in blindness.[122] Martin Wilsher was born prematurely to a mother who, having had no inkling that she was about to give birth, lost any chance there may have been to arrest her premature labour. During the baby's early, difficult weeks, he needed to be given a great deal of oxygen to keep him alive.

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[119] I am presenting this case in detail as it is an often cited medical one and still applicable.
[120] Miller (n 106) fn 42. 'Shape' is the term Lord Justice Musthill used in the Court of Appeal in *Wilsher* (n 71) to denote the particular circumstances which led to increased and eventuated risk.
[121] *Wilsher* [1987] QB 730 at 739, 779 (Sir Nicholas Browne-Wilkinson VC, approved by Lord Bridge at [1988] AC 1074, 1091).
[122] Retrolental fibroplasia is now known as retinopathy of prematurity. For discussion of medical understanding if its aetiology see AR Fielder 'Retinopathy of Prematurity: aetiology' (1997) 3 *Clinical Risk* 47-51. The following descriptive material is taken from Brooke (n 69) and J Badenoch QC, 'Brushes with Bolam Where Will It Lead?' *Address to Medico-Legal Society* (11 March 2004). Published (2004) 72 *Medico-Legal Journal* 4, 127.

He was subsequently found to have a peculiar form of blindness, known then as Retrolental Fibroplasia (RLF), and now as Retinopathy of Prematurity. This was widely believed to be caused by the effects on the premature retina of an excess of oxygen in the blood (hyperoxaemia), which doctors should be at pains to avoid. The defence admitted that the doctors had misplaced an umbilical catheter for monitoring the blood oxygenation. The doctors had thought the catheter was in the umbilical artery, but in fact it was in the vein, so they got falsely low readings and pumped ever more oxygen into a child whose lung transfer capability was better than it appeared. Long periods of hyperoxaemia resulted, and the legal team for the claimant felt the case would be won. However, 'this was in the dark ages of medical litigation, when we had no pre-trial exchange of expert reports, and pleaded defences were little more than denial, so we had no clear idea when the trial began of the precise medical grounds on which the case was being defended'.[123] According to Lord Brooke, 'the case was remarkable because it was almost the last example of trial by ambush'. The defence called four experts. The claimant's legal team did not see the reports until trial. At the end of the original trial, Mr Justice Pain did not make any findings of fact but did find that the doctors had not satisfied the burden of proof.[124]

When the case went to the Court of Appeal, it was found that there were five potential causes of the retrolental fibroplasias from which the boy, who was born at 26 weeks, suffered. RLF can occur in premature babies who have not been given additional oxygen and there is evidence of some correlation between RLF and several other conditions from which premature babies can suffer (apnoea, hypercarbia, intraventricular haemorrhage, patent ductus arteriosus), all of which affected the claimant. At the Court of Appeal, Mustill LJ put it: 'What the defendants did was not to enhance the risk that the known factor would lead to injury, but to add to the list of factors which might do so.'[125] The majority of the Court of Appeal held that *McGhee* could apply in these circumstances, recognising that this represented an extension of that case.[126] Browne-Wilkinson V-C, dissenting, took the view that the position was wholly different from that in *McGhee*: 'A failure to take preventative measures against

[123] Ibid Badenoch at 2.
[124] Brooke (n 69). See *McGhee v National Coal* Board (n 96) per Lord Wilberforce regarding shifting the burden of proof on to the defendant. This approach was negated by the House of Lords in *Wilsher* (n 71). Deakin et al (n 23) 251.
[125] *Wilsher* (n 121) 752.
[126] Deakin et al (n 23) 251.

one out of five possible causes is no evidence as to which of those five caused the injury.'[127]

The House of Lords reversed the decision of the Court of Appeal on this issue, approving of the judgment of the Vice-Chancellor.[128] In the end, Martin Wilsher's case addressed the special problems in medical cases and how a claimant must discharge the burden of proof. In short, he must prove that the negligent factor was probably, or at least, a material cause of his injury. If the negligent factor is but one among other non-negligent but equally possible causes of the injury, the claimant fails the causation hurdle.[129] The House of Lords approved *Wilsher v Essex AHA*[130] in *Fairchild v Glenhaven Funeral Services Ltd*[131] and said that it was correctly decided on its facts.[132] What legal principle distinguishes the *McGhee/Fairchild*[133] approach from the approach in *Wilsher*?

The House of Lords judgment in *Wilsher* went so far as to reverse the opinion of the Court of Appeal and to order a retrial on the grounds that the coincidence of a breach of duty and injury could not, of itself, give rise to a presumption that the injury was so caused: 'Whether we like it or not, the law…requires proof of fault causing damage as the basis of liability in tort'.[134] As noted, the difficulty for the claimant in *Wilsher* lay in the fact that there were five possible causes for the condition with which he was afflicted. One of these was medical negligence but it could not be established that this *possible* cause actually made a material contribution to the injury. It might have done so, but this fact still required to be proven by the plaintiff. The House of Lords discarded the notion that *McGhee* constituted an authority for transferring the onus of proof to the defendant. *McGhee* was to be distinguished from *Wilsher* in that there were

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[127] *Wilsher* (n 121) 779.
[128] *Wilsher* (n 71) Martin Wilsher's case was subsequently settled. See DG Kerry, 'Lawyer's Comment: Martin Wilsher -v- Essex Area Health Authority and Causation' (1991) 2 *AVMA Medical & Legal Journal* 4, 12 'When Martin Wilsher got his damages in full, many years after they had been awarded, but without interest, which would by that time effectively have doubled his money. ….and then as the crowning irony, researchers announced that the oxygen theory was conclusively proved, even to the extent of establishing the critical level of hyperoxaemia which was the culprit, and the other *Wilsher* suspects were all but completely eliminated.' Badenoch (n 122).
[129] Badenoch (n 122) 4.
[130] *Wilsher* [1986] 3 All ER 801.
[131] *Fairchild* [2002] 3 All ER 305.
[132] Jones (n 38) 463. Martin Wilsher's case was subsequently settled. Also *Murray v Kensington and Chelsea and Westminster Area Health Authority,* unreported, 1981, CA where the claimant failed to establish a causal link between excess oxygen he received and RLF.
[133] For discussion of *Fairchild* (n 36) see below 'The *Fairchild* Approach to Causation.'
[134] *Wilsher* (n 71) at 1094, [1988] 1 All ER 883, per Lord Bridge.

several agents which could have caused the injury in the latter but only one in the former. This provided an exceptional inference as to cause and, as a result, *McGhee* positively affirmed that the onus of proving causation lies on the pursuer or plaintiff.[135]

I would argue that the courts favour claimants in industrial cases over those in clinical negligence ones. While represented as a principle concerned with fact, it appears that what is involved in the strict interpretation of the 'but-for' test is a matter of policy and in clinical negligence cases this policy may defeat the claimants' claim. A limit is placed on the potential liability of the defendant by demanding that a particular nexus be shown. There are numerous circumstances, particularly in medical law, when the defendant's breach may have been part of the background leading to the claimant's damage. Nevertheless, if the defendant can show that the damage would have occurred anyway regardless of the breach of duty, then the claimant's action will fail.[136] The difficulties associated with the 'but-for' test in medical law are at their starkest when there are several causal factors contributing to the claimant's damage, or there are successive causes, each of which is sufficient. The intrinsic complexity of medical evidence means, therefore, that if the law fails to mitigate the strict application of the test, injustice may be done. I have made the point that in both *Bonnington* and *McGhee* the court took a *Fairchild* approach to causation,[137] namely, that the defendant's breach made a material contribution to the damage suffered by the claimant, or to the risk of damage to which the claimant was exposed. The inference was necessary because the lack of available evidence was such that the claimant could not meet the 'but-for' test. However, in *Wilsher*, the House of Lords was anxious to reassert the basic principle that the burden of proof always remains with the claimant, who must show either that the damage would not have occurred but for the defendant's breach, or that the breach made a material contribution to it. The difficult question for the medical lawyer, however, is in knowing when a court will draw an inference of fact based on common sense or pragmatism.[138] One plausible guide is the distinction which may be drawn between uncertainty created by the existence of a range of contributing factors, any or all of which may be judged cumulatively to have made a material contribution, and

[135] JK Mason, and GT Laurie, *Law and Medical Ethics*, 8th edn (Oxford, Oxford University Press, 2010) ch 5, 157.
[136] Kennedy et al (n 27) ch 6 Causation, 328-9.
[137] The *Fairchild* approach refers to a situation where a claimant can 'leap an evidentiary gap' discussed below**.** Kennedy et al (n 27) ch 6 Causation, 333.
[138] See *Chester* (n 36) (failure to warn about minimal risk of surgical complications) where the court found for the claimant on Human Rights Policy grounds. See below.

uncertainty created by the existence of a number of possible contributing factors, each of which is separate and distinct.[139] Where the factors are cumulative, the court may follow *Bonnington* but where the causes are distinct, the court would follow *Wilsher,* due to the impossibility of proving a causal nexus.

Another way of analysing the evidence emphasises 'historical involvement'.[140] In this sense, the requirement that the claimant establish that the tortious conduct was a cause-in-fact of his suffering actionable damage has two related parts: first, whether the tort was part of the history of how the claimant got to be where he actually was at the time of the trial; and second, where the claimant would have been, hypothetically, had the tort not occurred. Stapleton is concerned that a bare reliance on undefined causal terms can lead courts to fail to distinguish the *factual* issue of historical involvement from the *normative* judgement of which consequences of the tort fall within the appropriate scope of liability.[141] The 'but-for' test works well as a test for cause-in-fact in nearly all cases,[142] but it can be supplemented with a more sophisticated approach which Herbert Hart and Tony Honoré correctly identified as a reliable test for historical involvement.[143]

I have, up to this point, considered various approaches to proving causation in tort cases, namely, the 'but-for' test: the material 'contribution to harm' test; the 'concept of material contribution to the risk of harm' and finally 'a case or cases of alternative causes of harm'. I now turn to the question of when the courts are prepared, in the interests of justice, to accept evidential limitations. I would respectfully submit that the courts have been more generous in employer/employee situations, particularly where mesothelioma is at issue, than in medical negligence cases. As we will see when considering *Fairchild* and *Gregg v Scott,*[144] causation issues are clearly matters of legal policy and justice. The unfairness to claimants of requiring them to prove the impossible in circumstances where the defendant is in breach of duty is what usually leads the court to relax the normal requirements of proof. Indeed, in *Fairchild*, Lord Hoffmann

[139] Kennedy et al (n 27) ch 6 Causation, 334.
[140] Stapleton (n 39) 391-394.
[141] For more on this subject see Stapleton (n 39) 388 and A Honoré, 'Causation in the Law', *The Stanford Encyclopaedia of Philosophy* (Winter 2001 edn) E N Zalta (ed).
[142] Excepting cases of over-determination and joint determination. Stapleton Ibid and Honoré Ibid, plato.stanford.edu/archives/win2010/entries/causation-law/./
[143] A Honoré points out that 'Organic processes, such as those involved in the development of disease, and still more, in decision making by human beings, do not conform to settled patterns and therefore the NESS theory has at most a narrow range of application'. Honoré (n 141).
[144] *Gregg* (n 2) and *Gregg* [2005] 82 BMLR 52 (Loss of Chance case) considered below.

recognised that the distinction between a case involving a single agent and a number of different agents was not a principled distinction.[145]

4. The *Fairchild* Approach to Causation

Causation is not a strict technical matter which can be 'solved' by the application of quasi-mathematical formulas. Over many years, the courts have intervened to ease the frequently formidable factual difficulties of proving causation in cases of disease. This is well reflected in the cases I am about to discuss. In the case of *Fairchild*, which is a mesothelioma case but not a medical negligence case, the claimant had suffered multiple exposures to asbestos in the course of working for various employers and could not, strictly, demonstrate *who* had caused his disease.

In *Fairchild,* the House of Lords had to deal with a similar but more acute problem to that raised in *McGhee*. The workmen had been exposed to asbestos in breach of duty in the course of several different employments. They had developed mesothelioma. The expert medical evidence showed that mesothelioma can be triggered by a single asbestos fibre and it was impossible to say when that trigger had occurred. All that the experts could say was that the risk of the single fibre causing cell mutation was related to the extent of the exposure. So, each employer's negligence could be said to have contributed to the risk of injury but not to the injury itself. Even if the background risk could be dismissed, it could not be shown which employer(s) were responsible for the – possibly solitary – fatal fibre(s). This is by way of contrast to the lung disease asbestosis, which becomes incrementally more severe with increased duration of exposure, and to which any exposure to asbestos could, accordingly, be said to have contributed.[146] For these reasons, the Court of Appeal concluded that the claimants were unable to prove which of the defendants had caused the mesothelioma, and dismissed their claims.[147] The House of Lords, however, allowed the appeal on the basis that, in this exceptional case, it was sufficient for the claimants to show an increased risk of the disease consequent upon the defendants' negligence, even though actual causal contribution was impossible to prove.[148]

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[145] Jones (n 38) 466.
[146] See the lucid explanation of the factual difficulties by Brooke LJ in the Court of Appeal *Fairchild v Glenhaven Funeral Services Ltd* [2002] 1 WLR 1052 at 1063-1064.
[147] Ibid.
[148] J Morgan, 'Lost Causes in the House of Lords: *Fairchild v Glenhaven Funeral Services'.* (2003) 66 *Modern Law Review* 2, 277-284.

At the heart of four of the speeches was the conception of causation in law as a normative phenomenon.[149] The House of Lords thought that it was fair and just that an employer who had been in breach of duty to protect from asbestos exposure should be held liable even though it might not have been his asbestos fibre that had triggered the disease.[150]

As regards industrial disease cases, the House of Lords rejected the rationale that had been accepted in *McGhee* and also rejected Lord Bridge's explanation of it. On the facts of the mesothelioma cases, there was a clear difference between making a material contribution to the disease and making a contribution to the risk of the disease. To say that the two came to the same thing or should be deemed to be the same thing was fiction. The House of Lords did not wish to sanction a fiction so it held that cases such as *Fairchild* were to be a recognised exception to the 'but-for' rule. Where the exception applied, it would be enough for the claimant to show that the defendant's negligence had made a material contribution to the risk of injury, even though the injury might have been caused by the negligence of another defendant. Since *Barker v Corus UK Ltd*,[151] it is established that it is enough for the claimant to show that the defendant's negligence had made a material contribution to the risk of injury, even though the injury might in fact have been caused by some non-negligent factor, including a natural phenomenon, or by the claimant's own negligence.

As regards the scope of *Fairchild*, without caution the decision could be interpreted as creating a general principle that whenever the claimant has difficulty establishing causation but it can be shown that the defendant's breach of duty increased the risk of harm to the claimant, the rules of causation should be relaxed. In order to avoid this problem, their Lordships sought to limit the situations in which the normal requirements of the 'but-for' test could be dispensed with.[152] For present purposes, suffice it to say that the exemption is limited to mesothelioma cases.

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[149] Ibid for full discussion of the speeches. I will concentrate on the issues vis-à-vis clinical negligence.
[150] As noted above, in *Barker v Corus UK Ltd* [2006] 2 AC 572 the Law Lords ruled that each defendant should be liable only to the extent of their relevant contribution to the claimant's exposure to asbestos dust. In the specific context of claims for contracted mesothelioma, s 3 of the Compensation Act 2006 nullified that decision.
[151] *Barker v Corus*, Ibid.
[152] Jones (n 38) 466 for judicial reasoning and academic discussion.

In *Fairchild*, the judges overtly invoked policy considerations to support their modified approach to, and departure from, the usual strict rules of causation. In contrast, the harsh decision in *Wilsher*[153]stood. Lord Hoffman not only declared it to be correctly decided in principle, but also suggests that policy reasons to protect the NHS budgets could play a part in denying patient-claimants a more favourable approach to causation.[154]

In the later decision in *Gregg v Scott*,[155] Lord Hoffmann distinguished *Wilsher* and he observed that clinical negligence cases remain to be decided on a balance of probabilities. He noted that in *Fairchild*, their Lordships had:

> ...accepted that the disease had a determinate cause in one fibre or other but constructed a special rule imposing liability for conduct which only increased the chances of the employee contracting the disease. *That rule was restrictively defined in terms which make it inapplicable in this case.* Everything has a determinate cause, even if we don't know what it is. The blood-starved hip joint in *Hotson*, the blindness in *Wilsher*, the mesothelioma in *Fairchild;* each had its cause and it was for the plaintiff to prove that it was an act or omission for which the defendant was responsible. The narrow terms of the exception made to this principle in *Fairchild* only serve to emphasise the strength of the rule. The fact that proof is rendered difficult or impossible...because medical science cannot provide an answer, as in *Wilsher*, makes no difference. *What we lack is knowledge and the law deals with lack of knowledge by the concept of the burden of proof*.[156]

Lord Hoffmann makes it clear that the exceptional rule in *Fairchild* should not be generalised to clinical negligence cases:

> It should first be noted that adopting such a rule would involve abandoning a good deal of authority. The rule which the House is asked to adopt is the very rule which it rejected in *Wilsher's* case. Yet *Wilsher's* case was expressly approved by the House in *Fairchild* and *Hotson* too would have to be overruled. The House would be dismantling all the qualifications and restrictions with which it so recently hedged the *Fairchild* exception. There seem to me to be no new arguments or change of circumstances which could justify such a radical departure from precedent.[157]

The scope of the *Fairchild* exception has proved to be limited.[158] The difficulty in both *McGhee* and *Fairchild* is that the evidence did not establish either cumulative or

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[153] Discussed above.
[154] See below.
[155] *Gregg* (n 2) paragraphs 72-79.
[156] *Gregg* (n 2) paragraph 79. Added emphasis is mine.
[157] Ibid. at 85.
[158] See Smith (n 113) 107 for full discussion 'The only case in which the Fairchild exception was properly applied was *Transco Plc v Griggs*' [2003] EWCA Civ 564.

alternative causal mechanisms. *Bonnington Castings Ltd v Wardlow*[159] was a case of possible cumulative causes, one tortious and one not, and *McGhee*[160] was a case where there were two possible causative factors which were apparently alternative. However, in *Wilsher*,[161] the question was whether *McGhee* could be applied to a case where there were up to five discrete causes of the claimant's injury, any one of which might have caused the damage.

Looking broadly at policy issues, *McGhee/Fairchild* were cases where the defendants were employers and the claimants were employees with serious illness deemed, despite an evidential gap, to have a causal nexus with their employment. *Wilsher* was a case where the defendant was the Area Health Authority and the claimant was a patient.[162] The first decision, *McGhee*, could be seen as an instance of corrective justice. The House of Lords felt that the Court of Appeal's decision in *Fairchild* offends 'our sense of justice'. Lord Nicholls[163] said that '[a]ny other outcome would be deeply offensive to instinctive notions of what justice requires and fairness demands'. By contrast, the second decision, *Wilsher*, could be seen as an instance of distributive justice (concern for other patients).

It could be said that the judgment in *Wilsher* turned upon the identity of the defendants, the NHS, rather than an employer sued by an employee. Surely Lord Hoffmann cannot be correct in asserting that 'the massive increase in the liability of the NHS which would have been a consequence of the broad rule favoured by the Court of Appeal in *Wilsher's* case' might justify a different causation rule.[164] Of course, the policy issues that medical negligence litigation raises are important and are the subject of much political debate. Whatever the practical solution to these problems, it cannot be right to distort legal principle simply to protect one public sector defendant. The financial implications for insurance companies were not mentioned in any of the speeches.[165]

The interesting question arises as to where justice lies. The perceived unfairness of the lacuna in evidence did not sway the Court of Appeal in *Fairchild*, which set against the

[159] *Bonnington* (n 78).
[160] *McGhee v National Coal Board* [1972] 3 All ER 1008.
[161] *Wilsher* (n 71).
[162] See Lord Hoffmann's quote below.
[163] *Fairchild v Glenhaven Funeral Services Ltd.* [2002] UKHL 22 at para 36.
[164] Morgan (n 148).
[165] Ibid.

unpalatability of denying recovery to sympathetic claimants the injustice of requiring a defendant who may well have had no causal connection with the relevant injury to compensate the claimant's entire loss.[166] The House of Lords was content to assert that this injustice was 'plainly' outweighed by the injustice of the claimants recovering nothing.

As regards the distinction between *Wilsher* and *Fairchild*, Lord Hoffmann relied upon the identity of the defendant in *Wilsher*, and the medical negligence context:

> [I]t cannot possibly be said that the duty to take reasonable care in treating patients would be virtually drained of content unless the creation of a material risk of injury were accepted as sufficient to satisfy the causal requirements for liability. And the political and economic arguments involved in the massive increase in the liability of the National Health Service which would have been the consequence of the broad rule favoured by the Court of Appeal in *Wilsher's* case are far more complicated than the reasons given by Lord Wilberforce [in *McGhee*] for imposing liability upon an employer who has failed to take simple precautions.[167]

Lord Hoffmann's tantalising reference to the 'political and economic arguments involved in the massive increase in the liability of the NHS' raises many further questions: should the identity of the defendant matter? What about the point that the Occupiers' Liability Act 1957 applies equally to NHS hospitals as to brothels?[168] Could *Wilsher* be distinguished if the defendant in a similar case was a private hospital? Naturally, resource implications would have been raised by a favourable decision in *Wilsher*. Yet these have not stood in the way of other recent decisions on tort liability with vast socio-economic effects, notably *Heil v Rankin*, which effectively implemented the Law Commission's recommendations on the level of awards for non-pecuniary loss.[169] And in *Fairchild* itself, the sums were staggeringly high and the financial and insurance implications of the case were not mentioned in any of the speeches.

It seems clear to me that policy factors play a role here. Thus it is perhaps no accident that both *McGhee* and *Fairchild* were cases of employer's liability, a context in which the law has long acknowledged that policy places a strong emphasis on the maintenance by the employer of workplace health and safety,[170] whereas *Wilsher* was a case of

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[166] Ibid.
[167] *Fairchild* (n 36) and [2002] 3 WLR 89; Stapleton (2nd ref n 83) 276 and Morgan (n 148).
[168] Morgan (n 148) fn 39.
[169] *Heil v Rankin* [2001] QB 272; Morgan (n 148) fn 40. See also Chapter 6 Damages below.
[170] Deakin et al (n 23) ch 18, 257.

medical negligence, an area where the courts have, on the whole, sought to avoid doctrinal innovations which might, as they see it, lead to excessive liabilities.[171]

5. Clinical Negligence Cases: Does *Fairchild* Apply?

It is not surprising that the 'but-for' rule, which evolved in days of litigation over cattle trespass, fire and flood, is too crude a tool to provide a just solution in the context of litigation involving the complex causation of disease. This is true both in the arena of medical negligence and where there have been successive employments, where there is no clear scientific evidence as to causation. The judgments in *Fairchild* acknowledge the limitations of the 'but-for' test but stop short of proposing a new test or approach which would produce a just solution, not only in mesothelioma cases but generally in complex causation cases. Lord Rodger noted in *Fairchild*,[172] 'it is not necessarily the hallmark of a civilised and sophisticated legal system that it treats cases where strict proof of causation is impossible in exactly the same way as cases where such proof is possible'. But it is also true that, according to the rule of law, a just legal system must enunciate the circumstances in which exceptions to general rules will be permitted. Potential defendants, insurers and litigants need to know what these requirements are, and the reasons given to support them must be convincing.

The decision of their Lordships' House in *Fairchild* was never realistically in doubt.[173] Faced with defendants who had acted in breach of duty and claimants who had suffered injury as a consequence, with all the attendant political and media interest, it seemed extremely unlikely that the judgment of the Court of Appeal would be upheld. As noted above, Lord Nicholls said: 'any other outcome would be deeply offensive to instinctive notions of what justice requires and fairness demands.' Therefore, whereas the decision of the House of Lords in *Fairchild* was predictable, the real difficulty lies in elucidating in sufficiently specific terms the principle being applied in reaching the conclusion. 'To be acceptable, the law must be coherent. It must be principled.'[174] This difficulty has not disappeared as a result of the judgment given. The House of Lords has indicated that 'it

[171] Ibid. Hence the rejection of the 'loss of a chance' theory in *Hotson v East Berkshire AHA* [1987] AC 750 and *Greg* AC (n 63) 176, discussed below.
[172] *Fairchild* [2002] 3 WLR 89 at 168.
[173] C Feeney, P Laneng and D Cooper, 'Mesothelioma, Asbestos and Causation' (2003) 1 *Journal of Personal Injury Law*, 1.
[174] *Fairchild* (n 36) Lord Nicholls at paragraph 36.

would be unrealistic to suppose that the principle here affirmed will not, over time, be the subject of incremental and analogical development'.[175]

The House of Lords approached the cases on the basis that the competing potential causes were separate negligent exposures and it could not be shown which one was, in fact, causative. Therefore, for the foreseeable future, where the competing potential causes are successive negligent exposure of a similar type, causation will be satisfied if material contribution to risk is proven.

However, the position is more uncertain if the competing potential causes are exposures which do not amount to breach of duty or are dissimilar. The House of Lords' decision appears to leave open the possibility of arguing that the doctrine in *McGhee* does not apply to a situation where the other potential cause is a non-negligent cause, or where the competing causes render the injury more likely in different ways. Secondly, amendments to the test without considering the concept of indivisibility and apportionment may have provided justice for these claimants. However, holding defendants liable in full for injuries where they have only marginally increased the risk of the injury occurring, does not provide even-handed justice and, as it does not reflect the way in which the costs of such risks may be effectively distributed, may create a situation in which future claimants are denied compensation.[176]

Rather than 'incremental and analogical development', the outcome of *Fairchild* may demand an 'imaginative rule'[177] based on changing the concept of damages in 'indivisible injury' cases to render it workable for the future.[178]

In considering the application of *Fairchild* to other fact situations, William Coley[179] sets out Lord Hoffmann's reasons for deciding that *Wilsher* was correctly decided. Briefly, the explicit reasons are to do with the fact that *Wilsher* did not have the 'five ingredients' necessary for declaring liability.[180] However, as Coley points out, the implicit reasoning is a wish to limit the extension of the application of the

[175]Ibid. Lord Bingham at paragraph 34.
[176] See Smith (n 113) for analysis of the principles regarding apportionment of liability.
[177] Lord Hoffmann, describing the Supreme Court of California's judgment in *Sindell v Abbott Laboratories*, 26 Cal. 3d 588 (1980) para 74.
[178] Feeney et al (n 173) 14.
[179] W Coley, 'Fairchild: Unanswered Questions' (2003) *Journal of Personal Injury Law* 15 at 21.
[180] See Stapleton (2nd ref n 83) 281, 300-301 above regarding test for material contribution.

McGhee/Fairchild principle, particularly in medical negligence cases. The core question remains, of who carries the risk of injustice, the innocent victim or the wrongdoer. Further, as noted, context also matters. It is worth observing again that the claimant will fail even if there is, on the facts, a 49% chance that it was the hospital's negligence, as opposed to the other potential agents, that was the true cause of the adverse outcome (where the hospital has almost doubled the existing risk). The mesothelioma victim may possibly succeed where the defendant has only increased the existing risk by 5 to 10%.[181] In this sense, victims of clinical negligence could be seen as having lesser prospects of access to justice than employees. It is a sobering fact that the success rate for medical negligence actions is around 42% as compared with 84% for road traffic accidents and 79% for work place accident claims.[182] I would conjecture that the restrictive view of causation and the real difficulty in linking breach with damage in clinical negligence actions in large part accounts for the low success rate.

6. Modifying the Strict Rules:[183] *Chester v Afshar*[184]

I turn now to a *failure to warn* case. After presentation of the case and the House of Lords' judgements, I contrast framing an action regarding negligent advice in trespass or negligence. I then concentrate on the issues in suing in negligence and how the judges have extended the concept of causation beyond its normal parameters. Turning to the actual judgment, I analyse the willingness of the court to modify the rules on causation in order to effect justice. The court achieved this by accepting a modification of the normal rule of causation, as in the *Fairchild* judgment discussed above. I follow with discussion of the conceptual difficulty of *linking the failure to warn of a risk* with the *damage* sustained during non-negligent surgery. This was achieved by accepting a modification of the normal rule of causation as in the *Fairchild* judgment discussed above. I briefly touch upon the question of appropriate damages for trespass or negligence.[185] I note that there is academic opinion that modification of the rule was

[181] See Ibid regarding victims of negligent marketing of drugs, where there are a number of agents and a number of mechanisms and therefore the *McGhee* (n 70) principle to jump the evidential gap will not be applied, at 24.
[182] Jones (n 38) 13. Figures vary but the ratio remains similar.
[183] Brazier and Cave (n 7) 203.
[184] *Chester v Afshar* (n 5) and *Chester* (n 36). Full analysis of medical law regarding consent to treatment is outwith the remit of the thesis.
[185] For a fuller discussion of the symbolic and practical role of damages see Chapter 6 Damages below.

unnecessary[186] and that, by creating another exception to the rules of causation in negligence, the law has been left in a state of flux.[187]

a) Chester v Afshar*: The Case*

In *Chester v Afshar,* a patient-claimant benefited from judicial willingness to modify the strict application of the rules of causation. The surgeon treating the patient for serious back pain failed to disclose a low (1-2 per cent) but serious risk of nerve damage and paralysis inherent in the operation. This manifested itself and the patient sued in negligence claiming that had she been informed of the risk she would not have gone ahead with the operation when she did.[188] It was not established at trial, however, and the claimant did not argue, that she would never undergo the operation (and so never undergo the risk). It was, moreover, accepted that the risk in question was a constant: it was an integral part of the operation in question; it was irrelevant who performed it or when. Thereby an important issue arose as to whether it could meaningfully be said as a matter of law that the surgeon *caused* the patient's harm. Lords Hoffmann and Bingham (dissenting) were adamant and emphatic in their rejection of the claimant's case. For Lord Bingham, she had not met the basic requirements of the 'but-for' test – she had not shown that *but for* the failure to warn, she would never have undergone surgery.[189] Lord Hoffmann stated that there was no basis in the ordinary principles of tort law for recovery, and he was unconvinced that a special rule was needed in this case.[190] But it was precisely on this point that Lord Steyn, Lord Hope of Craighead and Lord Walker of Gestingthorpe (the majority opinion) took issue with their colleagues.[191] While each acknowledged that there could not be recovery on the 'standard rules', they argued, variously, that policy, justice, or the particular nature of decisions relating to one's health and well-being called for a departure from those rules. Common to their

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[186] J Stapleton, 'Occam's Razor Reveals an Orthodox Basis for *Chester v Afshar'* (Jul 2006) 122 *Law Quarterly Review* 426-448 at 426 'the consequence of the breach would fall within the *scope of liability* for consequences of breach in the tort of negligence'.

[187] K Mason and D Brodie, '*Bolam, Bolam*-Wherefore art thou *Bolam*?' (2005) 9 *Edinburgh Law Review* 298 at 305.

[188] The breach of the requisite standard of care requiring that the information should have been disclosed was not in doubt. Note the concern that 'the House of Lords has moved from upholding the professional standard of disclosure to accepting that of the subjective or prudent patient' in Mason and Brodie (n 187), at 302.

[189] *Chester* (n 36) para 8.

[190] Ibid. para 32.

[191] Support was drawn from the Australian decision in *Chappel v Hart* [1999] 2 LRC 341, which dealt with the same issue and there was also a division of opinion amongst the justices.

arguments was the view that these negligence actions are essentially concerned with protecting the patient's right to choose – therein lies her autonomy.[192]

i. The House of Lords' Solution

The House of Lords held by a majority that it did not matter that Ms Chester could not show that she would not have had the operation: in order to vindicate the claimant's right of choice and to provide a remedy for the breach in respect of that particular operation by that particular surgeon, a modification of the traditional principles of causation was required. As noted above, Lord Bingham and Lord Hoffmann would have dismissed the appeal. However, the majority (Lords Steyn, Hope and Walker) held that the issue of causation was to be addressed by reference to the scope of the doctor's duty to warn.[193] Their judgment was that this duty was central to her right to exercise an informed choice. Since the injury she sustained was within the scope of that duty and was the result of the risk of which she was entitled to be warned, the injury was to be regarded as having been caused by the defendant's breach of duty. In order to provide a remedy for that breach and to avoid the normal rule of causation from rendering the duty useless, justice required a narrow modification of that rule.[194]

b) Failure of Medical Advice: Trespass or Negligence?

Failure of medical advice by a doctor can vitiate a patient's consent to treatment, giving rise to battery, and it can also constitute a breach of the doctor's duty to inform, thereby bringing it into the scope of an action in negligence. Thus a failure to inform pertains to the torts both of battery and negligence.[195] The distinction between medical trespass and negligence, which is pertinent to my discussion of *Chester*, is based upon the difference between the types of medical advice that are not communicated. If the failure to inform

[192] Mason and Laurie (n 135) 119.
[193] The importance of the duty to warn, whatever its ideological basis or interest it protects, in practice then provides a basis for imposing liability for physical injury not caused by negligence. P Cane, 'A Warning about Causation' (Jan 1999) 115 *Law Quarterly Review*, 21-27.
[194] G Aldous, (ed), *Clinical Negligence Claims: A Practical Guide* 2nd edn (London, Chambers of G Aldous QC, 9 Gough Square, 2011) 82-83. The majority referred to the *Fairchild* case. The legal reasoning in finding causation was: 'What is clear is that if she had agreed to surgery at a subsequent date, the risk attendant upon it would have been the same, ie 1%-2%. It is therefore improbable that she would have sustained neurological damage' *Chester* (n 36) as per Lord Steyn at 11.
[195] Tan Keng Feng, 'Failure of Medical Advice: Trespass or Negligence?' (1987) 7 *Legal Studies* 2, 149-168 at 149. See this article for full discussion of the history of trespass actions and distinctions between trespass and negligence.

pertains to the *nature* of treatment[196] it relates to consent in trespass, and if it pertains to *risks* involved in treatment it is negligence.[197] Trespass is concerned with *protecting the patient's integrity* whereas negligence is concerned both with protecting the patients' interests in information and with the *standard of professional medical conduct*.[198] Nevertheless, where failure to warn is concerned, the patient's autonomy is curtailed as he loses the chance to decide which risks to undertake. (Where there has been carelessness in the medical treatment, the patient would normally sue in negligence.)

There are, however, differences between the two torts. In battery, a patient need not establish any tangible injury. *The actionable injury is the uninvited invasion of her body* and it is no defence to a charge of battery that the doctor thought the operation was in her best interests.[199] There is no requirement for the patient to prove that if she had been asked to consent to the relevant treatment she would have refused; nor is there need to show loss. The onus of proof of lack of consent lies with the claimant.[200] The disadvantages to the doctor of liability in trespass over negligence include: the doctor in order to defend himself must prove that there had been consent; the measure of damages may be wider (direct damages instead of foreseeable damages), causation is more easily established in trespass than in negligence, the benefit of therapeutic privilege is not available in trespass, medical trespass carries more reprobation against the doctor than negligence, and medical insurance may be less easily available in respect of medical trespass than negligence.[201]

c) Negligence, Causation and Informed Consent[202]

i. The problem

A doctor is usually under a legal duty to a patient to warn him in general terms of possible serious risks involved in a proposed treatment and, as noted, treatment without the consent of the patient is unlawful. Where the surgeon fails to give a warning of a

[196] *Appleton v Garrett* (1995) 34 BMLR an action in battery. Consent vitiated by fraudulent misrepresentation of practitioner.
[197] Feng (n 195). See footnote 19 at 153 for details.
[198] Ibid. Emphasis is the author's.
[199] Brazier and Cave (n 7) 115-116 with supporting case references. Note: If a patient is deemed to have capacity she can withhold consent even if decision appears to be contrary to her best interests.
[200] *Freeman v Home Office* [1984] 2 WLR 130.
[201] Feng (n 195) 165 also C Lewis and A Buchan, *Lewis and Buchan: Clinical Negligence*, 7th edn (Haywards Heath, Bloomsbury Professional, 2012) 212.
[202] A full discussion of the law regarding informed consent is outwith the scope of the thesis.

potential risk of complication[203] and the patient consents to the operation which *results in that very complication developing*, the patient is entitled to damages in negligence provided that, on normal principles of causation, he can establish that had he been properly warned he would not have consented to the procedure.[204] The patient must then show that the doctor's failure *caused the injury of which he complains.* It was the narrow question of causation that directly concerned the Law Lords in *Chester*.[205]

In what sense can a failure to warn of a risk which materialises be considered its *cause*?[206] It can be considered a necessary condition or a feature in creating a situation where the injury may occur but in common usage would not be a *cause.* However Peter Cane suggests it becomes a legal cause. Cane hypothesises that the courts distinguish *legal* notions of causation from *scientific* ones in their desire to stress that legal causation has to do with responsibility (a normative concept) whereas scientific causation does not. [207]

In *Chester,* the doctor was under a legal duty to warn of the possible serious risks involved in his proposed treatment. He failed to warn her of a small but serious risk of cauda equine syndrome which unfortunately eventuated. Deciding on whether or not the claimant would have consented had she been properly informed of the risk requires a subjective review of what that particular claimant would have done, albeit that the evidential testimony is after the fact. The patient's view may then be compared to notions of what a reasonable patient would have done; in other words, an objective test.[208] If the evidence is that the claimant would have gone ahead with the operation, even if warned of the risk, causation is not established.[209] The special feature in *Chester* is that the claimant was honest enough to say that she would not have proceeded on that occasion but would probably have undergone the operation subsequently.

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[203] There are varied thresholds of risk. In *Sidaway* (n 38) *per* Lord Bridges a 10% risk, in *Pearce v United Bristol Healthcare NHS Trust* (1999) 48 BMLR 118, a 0.1–0.2 % per Lord Woolf while noting *Sidaway* (n 38) applied the reasonable patient's standard of information disclosure. In *Chester* (n 36) the risk was 1–2%.
[204] Aldous (n 194) 83.
[205] Brazier and Cave (n 7) 113.
[206] See Cane (n 193) 22 discussing C*happel v Hunt* (1998) 72 A L J R 1344 (HC (Aus)).
[207] Ibid at 26 'Scientists deal in risks and probabilities, lawyers in responsibility and liability'.
[208] 'The objective test' *Smith v Barking, Havering and Brentwood Health Authority* [1994] 5 Med LR 285, per Hutchinson J.
[209] *Smith v Salford Health Authority* [1994] 5 Med LR 321.

d) **Chester** *and Damages*

In terms of compensation, in negligence, a defendant is only liable for the kind of damage which he reasonably ought to have foreseen.[210] In battery, the test is more stringent and the defendant may be liable for all the damage which can factually be shown to have flowed from the wrongdoing. As will be shown,[211] judges in England have sought to limit the scope of battery when it overlaps with negligence. The question then becomes 'for what is the patient being compensated?' *Chester* became an action in negligence but I agree with Grahame Aldous's[212] analysis that a patient's right to be duly informed of the risks of a proposed procedure would be more easily vindicated by an award of damages in trespass, which would then not have required any change to the principles of causation.[213] In addition, in *Chester* the measure of damages was on conventional negligence grounds, reflecting the difference between her condition following surgery and the condition she would have been in without surgery. If the focus were rather on the claimant's vindication of her rights, then the measure of damages allowed does not, in truth, reflect the loss suffered because at the end of the day, the loss lay in an invasion of autonomy *per se*, and an award of full damages can be said to over-compensate.[214] One approach would have been to 'offer a modest award or solatium'[215] to acknowledge the infringement of the claimant's autonomy by fault of the defendant, although it would have been difficult to fix a suitable price.[216] Another option would be to recognise a new tort of infringement of autonomy.[217] In the event, the judges in *Chester v Afshar* focused on the issue of causation in negligence and breach of contract accepting that, 'once the patient is informed in broad terms of the *nature* of the procedure, her consent to it is real and her cause of action for failure to warn is negligence, not trespass'.[218]

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[210] Brazier and Cave (n 7) 117.
[211] Below in this chapter.
[212] Aldous (n 194) 83. However, damages for the fact of trespass alone would be nominal. Lewis and Buchan (n 201) 212.
[213] Aldous Ibid.
[214] Mason and Brodie (n 187) 305.
[215] As in *Rees v Darlington Memorial NHS Trust* [2003] 4 All ER 987 discussed Ibid at 305.
[216] Per Lord Hoffman in *Chester* (n 36) at para 34. Arguments about distributive justice were not addressed, perhaps because the defendants were in the private sector. This difficulty about pricing non-pecuniary loss is a theme throughout the thesis.
[217] Mason and Brodie (n 135) at 306.
[218] *Chatterton v Gerson* [1981] 1QB 432; approved in *Sidaway* (n 38).

e) Tort after Chester

It is the concept of moral responsibility and wrongdoing which pervades the majority opinion in *Chester*. The Lords were candid in dealing with the causation issue and, while accepting that the claimant would fail on conventional causation rules, found a way for her to succeed. This leaves causation rules in flux as there is uncertainty about when the court will opt for policy over rules. *Chester* was a case in the private sector. I argue that liability to damages for failure to disclose a 1–2 per cent risk could be very costly indeed in the context of NHS settings and budgets.[219] One should perhaps look at the potential severity of the risk as well as the likelihood of it materialising. Also, I believe that the judgment in *Chester v Afshar* was punitive to the defendant, who was not negligent in the performance of the surgery.[220]

Although the Law Lords in *Gregg v Scott*[221] discuss the difficulties in clinical negligence cases, there does not appear to be any commitment to extending the 'rule' to jump evidential gaps. In *Chester*, the policy issue concerned the new emphasis on the Human Rights Act 1998, but Lord Hoffmann, giving a vigorous dissenting judgment, said: 'the wholesale adoption of possible rather than probable causation, the criterion of liability, would be so radical a change in our law as to amount to a legislative act'.[222] He emphasised that such a change would have enormous implications for insurers and the NHS and, as such, it should be for Parliament rather than the judiciary to decide whether it should be introduced. Once again we see the tension between corrective justice for the individual (or class of victims) and distributive justice as to the distribution of funding risks. The courts at this point often suggest 'this is a decision for Parliament'. While Baroness Hale seeks to contend that *Chester v Afshar* was a case confined to '…problems which could be remedied without altering the principles applicable to the great majority of personal injury cases which give rise to no real injustice or particular problems',[223] I agree with Emily Jackson[224] that a successful claim in negligence for failure to disclose a material risk is, in practice, synonymous with strict liability for medical mishaps and therefore problematic. The requirement of

[219] In contrast, in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1984] QB 493, the standard for disclosure of risk was set at 10 per cent.
[220] E Jackson, *Medical Law* 2nd edn (Oxford, Oxford University Press, 2010) 206.
[221] *Gregg* (n 2) see below.
[222] *Fairchild* v *Glenhaven* (n 36) at 90. See also S Green, 'Coherence of Medical Negligence Cases: A Game of Doctors and Purses' (2006) 14 *Medical Law Review* 1.
[223] In *Gregg* (n 2) para 192.
[224] Jackson (n 220).

informed consent then becomes a route for patients to seek financial compensation for unfortunate but blameless medical outcomes. Doctors who exercised all reasonable care and skill in performing an operation would be found liable for the consequences of an accident which they could have done nothing to prevent, just because their pre-operative disclosures were inadequate.[225]

IV. LOSS OF CHANCE

Frequently, the claimant's complaint in a medical negligence action is not that the doctor has inflicted 'additional' injury, but that, as a result of the defendant's negligence, his medical condition has not been improved or has been allowed to deteriorate. Accordingly, the claimant has been deprived of the opportunity of making a full or proper recovery from the illness or injury for which he first sought treatment. Applying the 'but-for' test of causation, if, on the balance of probabilities, competent treatment would have prevented the deterioration which has occurred, or produced an improvement, the negligence is causally related to the damage and the defendant is responsible.

Where, however, the patient's prospects of a successful outcome to the treatment were estimated to be less than 5%, the patient cannot satisfy the test, because even with proper treatment the damage would probably (that is, more likely than not) have occurred in any event.[226] These are the cases which provide the present challenge to the English courts. There is a real question whether the loss of a chance approach is applicable in medical negligence cases where an adverse result is suffered for which there was a substantial probability even without negligence, but negligence has materially increased that probability.[227]

In her seminal article 'The Gist of Negligence',[228] Jane Stapleton sets out the theoretical framework for formulating the gist of an action in negligence, not in terms of 'the outcome' (past fact) but in terms of the lost chance of avoiding the outcome. She argues that the most important impact of uncertainty about what is or could be the actionable

[225] Ibid.
[226] In medical cases this would be where the background risk is substantial (over 50%) and the claimant is met with the argument that the outcome was caused by the background risk.
[227] For a full comparative discussion of the law in England and Australia see *Rufo v Hosking* [2004] NSWCA 391 (1 November 2004).
[228] Stapleton (n 28) 389.

'damage' in a negligence action is on the requirements for the proof of causation, since the causation issue is subordinate to and defined by the question of what forms the gist of the action.[229] While the Court of Appeal in *Hotson v East Berkshire Health Authority*[230] accepted that pure loss of chance, that is, one not consequential on existing physical or financial loss, could become a category of loss, the House of Lords' decision in *Hotson* left open the question of whether or not loss of chance could be a successful negligence claim.

The inherent unfairness of not recognising a 'loss of chance' itself as a compensable cause of action was stated by Justice Dore in the American case of *Herskovits v Group Health Co-operative of Puget Sound*.[231] In this case, due to the negligent failure to diagnose the patient's tumour, the patient's survival rate for more than five years was reduced from 39% to only 2%. The court allowed the case to go to the jury on the question of proximate cause, although the 'loss' constituted the 14% reduction in the chance of survival, and any damages would be limited to the loss attributable to the premature death, not the death itself. J Dore pointed out that: 'To decide otherwise would be a blanket release from liability for doctors and hospitals any time there was less than a 50% chance of survival, regardless of how flagrant the negligence'.[232] This comment was echoed in the observations of the Court of Appeal in *Hotson v East Berkshire Area Health Authority*[233] that, applying the all-or-nothing approach to a patient whose chances of a successful outcome to his treatment were less than 50%, means the patient has no action against the doctor no matter how negligent he has been. This creates what is, in effect, an unenforceable duty to exercise reasonable care.

The way of analysing these cases was suggested by Judge Advocate Santow in the New South Wales case of *Rufo v Hosking*:[234]

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[229] 'It cannot be overemphasised that the formulation of the 'damage' forming the gist of the action defines the causation question.' Ibid at 393.
[230] *Hotson* (n 171).
[231] *Herskovits v Group Health Co-operative of Puget Sound* 664 P. 2d 474 (1983) (Washington SC). This decision was discussed by Lord Mackay in *Hotson* (n 171) 786-789.
[232] Stapleton (n 28) 477. See Jones (n 38) ch 5, 493.
[233] *Hotson* (n 171).
[234] *Rufo v Hosking* (n 227) para 20 quoting Lord Diplock in *Millett v McMonagle* [1070] AC 166 (HL) at 176. *Rufo v Hosking* is a very recent case of medical negligence dealing with recoverability for loss of a less than 50% chance of avoiding spinal microfractures suffered in the course of heavy dosage treatment with corticosteroids against lupus. The UK *Fairchild* approach to causation, which the House of Lords applied to a closely defined set of circumstances, was seen as inapplicable to the situation of 'loss of chance' in a medical negligence case. Paragraphs 433-437.

> The role of the court in making an assessment of damages which depends upon its view as to what will be and what would have been is to be contrasted with its ordinary function in civil actions of determining what was. In determining what did happen in the past a court decides on the balance of probabilities. Anything that is more probable than not it treats as certain. But in assessing damages which depend upon its view as to what will happen in the future, or would have happened in the future, if something had not happened in the past, the court must make an estimate as to what were the chances that a particular thing will or would have happened and reflect those chances, whether they are more or less even, in the amount of damages which it rewards.

He goes on to say that the High Court in *Malec v J C Hutton Pty Ltd (1990)*[235] added an important refinement, namely, to include past events of a hypothetical character in the 'what would have been' category where loss of chance or prospect holds sway. This renders those past events, being of a hypothetical character, amenable to compensation on a lost chance basis, though that chance be less than even, provided the duty of care extends so far.[236]

A. Historical Loss of Chance Case: **Hotson**

English courts have so far decided against loss of chance liability in medical negligence cases.[237] The governing principles at present are those elucidated by the House of Lords in *Hotson v East Berkshire Area Health Authority.*[238] In *Hotson* the claimant suffered an injury and was referred to hospital where a doctor negligently failed to diagnose a hip injury. Five days later the boy returned to hospital, at which time the hip injury was discovered. However, by this time the hip injury had also resulted in a deformity of the hip joint. The defendants argued that the deformity would have occurred whether or not a timely diagnosis had been made during the first visit at the hospital.

The trial judge found that the Health Authority's delay in diagnosis denied the claimant a 25% chance of avoiding the hip deformity. He thus gave the claimant 25% of the amount of damages he would have received had the injury been solely caused by the delayed diagnosis. Simon Brown J held that, where a 'substantial chance' of a better medical result had been lost, it was not necessary to prove that the adverse medical result was directly attributable to the breach of duty because the issue was the proper quantum of damage rather than causation.

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[235] *Malec v J C Hutton Pty Ltd (1990)*169 *Cambridge Law Review* 638.
[236] *Hotson v East Berkshire Area Health Authority* [1987] 1 All ER 210 (CA); [1987] 2 All ER 909 (HL) (referred to as *Hotson).*
[237] JA Santow in *Rufo v Hosking* (n 227) para 19 at 19.
[238] *Hotson* (n 236 both refs).

This approach was upheld by the Court of Appeal, where Sir John Donaldson MR characterised the claim as the loss of benefit of timely treatment, rather than the chance of successful treatment. His Lordship said that the use of the word 'chance' was inaccurate because it elides the identification of the loss with the evaluation of the loss, which are distinct processes. Just as the categories of negligence are never closed, there was no reason why the categories of loss should be closed either.[239] The Court of Appeal agreed with the Master of the Rolls, saying: 'As a matter of common sense, it is unjust that there should be no liability for failure to treat a patient, simply because the chances of a successful cure by that treatment were less than 50%.'[240]

The House of Lords reversed the Court of Appeal, however, on the basis that the judge's finding that there was a high probability put at 75%, that even with the correct diagnosis and treatment the claimant's disability would have occurred, amounted to a finding of fact that the accidental injury was the sole cause of the disability.[241] In other words, this was not a 'lost chance case', it was an 'all-or-nothing' case – either the fall or the misdiagnosis caused the disability, and on the balance of probabilities it was the fall. The valuation of a 'lost chance' would only arise once causation had been established. As has been pointed out, however, this decision fails to address the essence of the claimant's argument, which was whether a claim formulated as a loss of chance was acceptable.[242] If the nature of the damage could be redefined as the loss of a chance of a successful outcome, rather than the outcome itself (the disability) then on a traditional causation test the defendant's negligence clearly did cause the damage (that is, the lost chance). Logically, the question of whether the defendant's negligence caused damage is an issue that can only be dealt with *after* the nature of the damage has been defined.[243] The question of whether it would ever be possible to claim for loss of a chance in tort was specifically left open by their Lordships in *Hotson.*[244]

The wider question remains as to whether, in a claim for personal injury, it would ever be appropriate to award the claimant a proportionate fraction of the full damages where

[239] *Hotson* (n 171) 761.
[240] Ibid at 215.
[241] *Gregg* (n 2).
[242] Stapleton (n 28) 389.
[243] See Jones (n 38) ch 5, 496 for a fuller discussion of the courts' attitude to statistical evidence; and the question of 'loss of chance' cases in contract law at 498.
[244] The Supreme Court of Canada has expressly rejected the loss of chance theory: *Laferriere v Lawson* (1991) 78 DLR (4th) 609 (SCC).

the cause of the injury was unascertainable and all the claimant could show was a statistical chance that was less than even (ie less than 50%) that, but for the defendant's breach of duty, he would not have suffered the injury. *Hotson v East Berkshire Authority,*[245] which left open the question of compensation for loss of chance, appears to stand in the way unless it is distinguishable on the basis that, as Mance LJ explained in the Court of Appeal,[246] *Hotson* was dealing with a past historic fact, not one in prospect. It was, moreover, a case where the adverse consequence of that past fact was inevitable in any event, for example with the result that negligent failure to diagnose in time a traumatic fracture of the femur had no causal effect on the necrosis.

There are unquestionably policy issues standing in the way of the courts' acceptance of loss of chance as the gist of a negligence action in medical negligence cases. As has been seen above, *Wilsher v Essex AHA*[247] was found to have been correctly decided by Lord Hoffmann in *Fairchild v Glenhaven Funeral Services Ltd*.[248] As noted earlier, fundamental to Lord Hoffmann's thinking was the cost to the Health Service of extending liability. Stapleton[249] points out that, if the claimants' arguments succeed, the likelihood is that more loss of chance claims would be eligible but that the value of the awards across the board would decrease as damages would be awarded on a percentage basis.[250] This issue arose directly in the case of *Gregg v Scott*.[251] I will present the factual context of the case, followed by the judgments in the Court of Appeal and the House of Lords, and conclude this section with a brief discussion of loss of chance cases.

B. Loss of Chance: Gregg v Scott

The claimant had non-Hodgkin's lymphoma. His doctor negligently diagnosed a benign lipoma. The judge found that the negligent delay reduced the claimant's chance of ten-year survival from 42% at the date of the relevant consultation to 25% at the time of trial. It was therefore not possible to conclude, on the balance of probabilities, that

[245] *Hotson* (n 171).
[246] *Gregg v Scott* [2002] EWCA Civ 1471 paragraph 85, (hereafter *Gregg* EWCA).
[247] *Wilsher* (n 71).
[248] *Fairchild* (n 36); [2003] 1 AC 32 See Lord Hoffman at para 70, Lord Bingham at para 22, Lord Rodger at paras 149 and 170.
[249] Stapleton (n 28) 405.
[250] What would be quantified would be the lost chance rather than the full damage.
[251] *Gregg* EWCA.

earlier treatment would have affected the chance of ten-year survival. The claim, therefore, failed.

The trial judge, applying *Hotson,* dismissed the claim on the basis that, for a person with his condition, the chances of a cure were in any event less than 50%, so that as a matter of past fact, it was more probable than not that the claimant would have been in his present position even if treatment had started promptly. The Court of Appeal, by a majority, dismissed the claimant's appeal. In the House of Lords, the claimant advanced two arguments. The first was the 'quantification argument' that the delay in diagnosis had caused physical damage. The second was the 'loss of chance' argument that the case was factually different from *Hotson*, so that *Hotson* did not preclude a claim based on a reduced prospect of survival; but even if *Hotson* did apply, the decision in *Fairchild* permitted the court to depart from it. By a 3:2 majority, the House of Lords rejected the claim. Unfortunately, given the significant disparities in their Lordships' speeches, no clear principle has emerged. Despite the majority decision that Mr Gregg's action should be dismissed, it remains arguable that in some circumstances a missed diagnosis could give rise to a claim based on a lost chance of a better medical outcome.[252]

1. *Gregg v Scott* in the Court of Appeal

The Court of Appeal, by a 2:1 majority, upheld the trial judge's ruling on the basis that, because the chance of survival at the time of the defendant's negligence was below 50%, following *Hotson v East Berkshire Health Authority,*[253] the defendant could not be held causally responsible.[254] The majority of the Court of Appeal rejected the claimant's arguments, albeit on differing grounds. Mance LJ distinguished *Hotson* on the basis that in *Hotson* the avascular necrosis was inevitable whereas, in this case, the defendant's negligence had led to the spread of the tumour. He distinguished between cases where the evidence was purely statistical (as in *Gregg)* [255]and where it leads to a finding of fact about the claimant's own injury (*Hotson*). Mance LJ took the view that *Hotson* left open the possibility of a 'loss of chance' claim in 'a statistical case' as the doctor's duty in

[252] Jones (n 38) 493.
[253] *Hotson* (n 171).
[254] See Lord Phillip's judgment in *Gregg* (n 2) regarding statistical analysis.
[255] On which see T Hill, 'A Lost Chance for Compensation in the Tort of Negligence by the House of Lords' (1991) 45 *Modern Law Review* 511 for a discussion of a 'statistical chance' in comparison with 'a personal chance'.

such a case was to maximise the chances of survival. That purpose militated in favour of liability when the doctor's negligence decreased the chances of the claimant surviving. However, Mance LJ accepted that policy considerations should lead to its rejection in clinical negligence cases:

> I think that to accept the appellant's suggested approach in the present (very common) category of medical negligence case, involving failure to diagnose, would both open a considerable gate to claims based on percentages, and create a new category of case which will be difficult to distinguish in practice from other common cases of medical negligence.[256]

He rejected, however, the contention that the growth of the tumour due to the defendant's negligence was a tort in itself. He also rejected the argument that *Fairchild* enables a more flexible approach to determining causation. Brown LJ found nothing in the claimant's case to distinguish it from *Hotson* and agreed that nothing in the speeches in the House of Lords in *Fairchild* supported a more relaxed approach to determining causation. 'With considerable regret',[257] he dismissed the appeal.

Latham LJ delivered the dissenting judgment. He agreed with Mance LJ that *Hotson* was distinguishable on the grounds that, in this case, the defendant's negligence made the claimant's position worse. In his opinion, once it had been established that the defendant's negligence had allowed the spread of the tumour, liability was established and it was merely a function of quantum to assess the consequences of that negligence (the reduced prospects of successful treatment). However, Latham LJ[258] saw the dangers of applying this approach to cases of 'loss of chance *simpliciter*' where the claimant has been exposed to a risk of injury but has not yet suffered any injury. Such claims would be 'speculative' being based solely on the risk of future injury. It was different, however, where the claimant had suffered injury that necessarily included 'the loss of a chance of some benefit'.

Thus, the Court of Appeal, while recognising that 'the common man might have some difficulty understanding why damages were not recoverable', stepped back from taking the enormous step of recognising loss of chance cases in the context of medical negligence claims. The decision is important because it re-affirms that the *Fairchild*

[256] *Gregg* EWCA (n 251).
[257] Ibid. at paragraph 104.
[258] Also see Stapleton (n 28) 405.

decision is a decision on its own particular facts and, while there may be other analogous situations where a *Fairchild* approach to assessing causation is appropriate, that category of case is to be kept within strict limits and the balance of probabilities remains the guiding principle to determining causation.

2. Loss of Chance in the House of Lords

a) The Claimant's Arguments: The Quantification Argument[259]

As noted above, in the House of Lords the claimant advanced two lines of argument. Firstly, he said, no novel question about the recoverability of damages for a loss of chance arose at all. It was common ground that the delay caused some spread of cancer cells which could and should have been avoided. That spread was physical damage in the conventional sense. The tort was fully consummated: there was a breach of duty, and that breach had caused loss. The claimant was therefore entitled to succeed. The only remaining question was how much the claim was worth. Once one was in the realm of quantification there was nothing unusual about the idea of damages for a lost chance. Valuing the lost chance might be practically difficult, but not conceptually demanding. The House referred to this as the 'quantification argument'.

The quantification argument, although found persuasive by Latham LJ in the Court of Appeal,[260] foundered in the House of Lords.[261] Lord Hoffmann said that it begged the question raised in the second argument, namely, whether a loss of chance was compensable:

> It is true that the delay caused an early spread of the cancer and that this reduced his percentage chance of survival for more than ten years. But to say that the claimant can therefore obtain damages for the reduction in his chances of survival assumes in his favour that a reduction in the chance of survival is a recoverable head of damage; an issue raised by the claimant's second argument. On the other hand, if the claim is actually for depriving him of survival for more than ten years, the question is whether the spread of the cancer caused it. The judge's finding was that it did not. It was likely that his life would have been shortened to less than ten years anyway (ie by the disease).[262]

[259] For facts of the case see above.
[260] *Gregg* EWCA (n 251). paragraph 41.
[261] *Gregg* (n 2). Paragraphs cited below refer to this judgment.
[262] *Gregg* (n 2) Lord Hoffmann para 71.

Lord Hoffmann and Baroness Hale pointed out that before one gets to the stage of quantification, the causal connection between a tort and consequential loss of any kind has to be proved on the balance of probabilities – precisely what could not be done here:

> Consequential loss still has to be consequential upon, that is caused by, the injury that has been caused by the Defendant's negligence. If I am injured in a road accident, I still have to prove that any earnings I have lost are caused by that injury and not by, for example, my decision to give up work and go round the world.[263]

b) The Loss of Chance Argument

The second argument was the undiluted loss of chance argument. This asserted that a lost chance was a real loss and should be recognised as such by the law.[264] Charles Foster explains the contrast between the majority and dissenting judgments as the tension between justice 'best achieved by legal certainty' and justice demanding a relaxation of the old rules of causation, thereby allowing compensation in an individual case.[265] The difference could also be described as the tension between corrective justice for the individual and distributive justice for the overall patients of the National Health Service.[266] Both approaches have merit.

In the House of Lords it was accepted that the cursory examination of the patient by his GP was negligent;[267] the crux of the matter was whether this had caused a recognised legal harm. In the final analysis, the claimant argued that his 'harm' was the loss of the chance of survival for more than ten years or, put differently, the loss of a chance of a more favourable outcome to his prognosis. Statistical evidence indicated that while the claimant might have had a 42% chance of still being alive after ten years if there had been no negligence, this chance was reduced to 25% because of the negligence. There was, therefore, a significant drop in his statistical chances as a result of his misdiagnosis, but – crucially – at no point did he enjoy a more than 50% chance of

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[263] *Gregg* (n 2) Lady Hale para 200.
[264] The issue of loss of chance claims in other areas of law is addressed by Lady Hale in *Gregg* (n 2) paragraph 220 and by Foster (n 48) 248 at 2.
[265] Ibid at 3.
[266] If the Health Service were a private enterprise, the contours of the arguments might be different. See J Bartholomew, *The Welfare State We're In* (London, Politico's Publishing 2004) ch 3 'The NHS: Like A Train Crash Every Day'.
[267] The exposition of the arguments in the House of Lords is taken from Mason and Laurie (n 187) at 161.

survival beyond ten years.[268] On a strict application of *Hotson* and the balance of probabilities test, then, the GP did not cause the alleged harm: it was not 'more probable than not' that, but for the negligence, the patient would be alive after ten years. The trial judge found that he probably would not be. Put another way, even without the negligence, there would have been a 58% chance that the patient would not survive the decade.

This outcome was unacceptable to Lords Nicholls and Hope (dissenting). Lord Nicholls, in particular, argued forcefully that the 'all-or-nothing' approach to what would have happened but for the negligence – that is the application of the 49/51% rule from *Hotson* – was premised on a falsehood. Namely, that '…a patient's prospects of recovery are treated as non-existent whenever they exist but fall short of 50%'.[269] This then led to arbitrary and unjust outcomes: '[i]t means that, a patient with a 60% chance of recovery reduced to a 40% prospect by medical negligence, can obtain compensation. But he can obtain nothing if his prospects were reduced from 40% to nil.[270] And Lord Hope opined that the principle on which a patient's loss as a result of negligence is to be calculated – and presumably recompensed – is the same whether the prospects were better or worse than 50%.[271]

The majority, however, rejected the appeal and did so largely to protect the integrity of legal principles. Lady Hale distinguished the House's ruling in *Fairchild* and *Chester* as cases 'dealing with particular problems which could be remedied without altering the principles applicable to the great majority of personal injury cases which give rise to no real injustice or practical problem'.[272] She considered the instant case to be an invitation to introduce 'liability for the loss of a chance of a more favourable outcome'. But she refused to do so because of the complexities involved and the consequences this would have. Those consequences were largely summed up by Lords Phillips and Hoffmann. In their view, a departure from *Hotson* would change the basis of causation from probability to possibility, that is, that some form of recovery would be due if it was shown that it was possible that the negligence might affect a patient's case. Not only

[268] The significance of the criterion of 'survival at 10 years' is that this is generally acknowledged as amounting to a 'cure' in medical circles. The relevance of this to a legal concept of 'cure' was rejected by *Gregg* (n 2) Lady Hale, paragraph 197.
[269] *Gregg* (n 2) Paragraph 43.
[270] *Gregg* (n 2) Paragraph 46.
[271] *Gregg* (n 2) Paragraph 121.
[272] *Gregg* (n 2) Paragraph 192.

should this be a matter for Parliament, but as Lady Hale put it: 'it would in practice always be tempting to conclude that the doctor's negligence had affected…[the claimant's] chances to some extent'. Lord Hoffmann suggested that to extend the *Fairchild* principle, without identifying any control mechanisms to limit its application, would amount to a legislative act and have 'enormous consequences for insurance companies and the National Health Service'.[273] And, finally we have Lord Phillips: 'it seems to me that there is a danger, if special tests of causation are developed piecemeal to deal with perceived injustices in particular factual situations, that the coherence of our common law will be destroyed'.[274]

To conclude this section, it is important to be clear about what recoverable losses in respect of missed diagnosis of cancer are presently compensable. Where it is possible to identify something specific that a claimant has lost as a result of a diagnostic error, rather than a 'mere' statistical chance, then the claimant is entitled to compensation for that loss. Their Lordships in *Greg v Scott* accepted that if a delayed diagnosis had resulted in extra pain, suffering, loss of amenity and financial loss due, for example, to the patient having to face more drastic medical intervention than would have been the case, then compensation for this loss would be payable. Baroness Hale also seemed to accept that a modest claim for reduction of life expectancy could arise where the claimant's life expectancy had been reduced compared to patients in the claimant's position who had received prompt treatment, even if the patient was in the category of patients who, with prompt treatment, would probably have died.[275] As we see below, this analysis appears straightforward.

C. Discussion of Loss of Chance

Should medical negligence cases allow a remedy to the claimant whose injury, more likely than not, would have occurred without any negligence on the part of the doctor, but where that negligence nonetheless denies the claimant a material chance of a better outcome? As Andrew Grubb sees it,[276] the way Latham LJ[277] rationalises the *Gregg* case, the claimant would succeed on conventional grounds. He had suffered a physical

[273] *Gregg* (n 2) Paragraph 90.
[274] *Gregg* (n 2) Paragraph 172.
[275] Jones (n 38) 161.
[276] Grubb in Deakin et al. (n 23) ch 3 of 5th edn, 1. Problems of Medical Law, p 261 and comment on p 325.
[277] *Gregg* EWCA (n 251).

injury (the enlarged tumour) which consequentially reduced the claimant's chance of survival. So rationalised, it is indistinguishable in principle from a case of physical injury, say to the head, which creates a future risk of epilepsy. The claimant is entitled to recover for risk of future injury. Here, the claimant is entitled to recover for the risk that his life will be cut shorter than it otherwise would.[278]

Grubb goes on to discuss the question of a 'pure' loss of a chance. Whether the law should allow recovery for a statistical chance of injury, or avoiding injury, involves policy arguments on both sides. Courts throughout the world have tried to grapple with this issue but with no unanimity of approach or outcome.[279] Grubb remains rather sanguine about the subject, saying that 'the volume of judicial and academic words devoted to this issue may be misplaced':

> In reality, Brown LJ in *Gregg v Scott* is probably right that it is impossible to visualise where a claim could arise apart, that is, from the 'loss of chance simpliciter' cases. Either the claimant will suffer injury and be able to establish (or not as the case may be) that the defendant's negligence caused that injury or 'the chance' will be conceptualised as a future risk/benefit which can be linked and grounded in actual physical injury suffered by the claimant. Latham LJ's interpretation of the facts in *Gregg v Scott* has much to commend it.[280]

Nevertheless, it is interesting to see what factors must be shown if a 'loss of chance' action materialises.

It is instructive to see how Santow JA analyses the question in the recent New South Wales case of *Rufo v Hosking*.[281] This is a case of medical negligence dealing with recoverability for loss of a less than 50% chance of avoiding spinal microfractures suffered in the course of heavy dosage treatment with corticosteroids against Lupus. It shows that while intermediate courts of appeal in Australia do not yet have the guidance of a High Court decision affirming 'loss of chance' in medical negligence, the trend of intermediate appellate and first instance authority in Australia favours that approach.

Santow JA suggests that there is much to be said for consistency, whereby a chance above or below 50% obtains no more or no less in compensation than the corresponding

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[278] See Grub (n 23) at 323 fn 476 (Mance LJ and Brown LJ did not accept this analysis). Also fn 477 on valuing a 'diminution of life expectancy'.
[279] Grubb (n 23) 261; see *Rufo v Hosking* (n 227) below.
[280] Grubb (n 23) 324.
[281] *Rufo v Hosking* (n 227) para 52. See also discussion in Jones (n 38) 513.

percentage, instead of an all-or-nothing approach. That should not open the floodgates to loss of chance claims in the medical negligence field. The loss of chance must itself be established on the balance of probabilities (that it was a real chance) as also that the chance, if offered, would have been taken.[282] Another limiting factor is that the question, why should there be recovery for loss of a chance when less than even, turns on the nature of the duty of care imposed on the medical practitioner. Doctors are not, and cannot be, guarantors of outcomes. What their duty encompasses is reasonable skill and care directed to achieving the best possible medical outcome and thus to eliminating or reducing so far as practicable, the risk of things going wrong. The case of *Rufo* was a case where the loss of a chance does afford a proper basis for compensation. It highlights the importance of considering the duty of care not in isolation, but in conjunction with a fair assessment of the difficult task facing a doctor having to choose between various options, each with their own risks. Santow JA concludes his judgment with a quote from Harold Luntz:[283]

> Where a medical practitioner fails to exercise reasonable care, the aim of the law generally is not to reposition the plaintiff as though no treatment had been given, but as though proper treatment had been given whether the claim lies in contract or tort. In many instances proper treatment could have done no more than give the plaintiff a chance of cure or alleviation of a pre-existing condition. This is something of value, something for which many people would give money. The law should treat such a chance as worthy of protection.

It is still possible to talk about the law of causation. Many wondered, in the light of *Fairchild* and *Chester v Afshar* whether causation was 'being drummed off the tortious stage' by amorphous principles of fairness, principles so strident that they never stopped to ask whether it was fair to make someone pay for something he had not caused.[284]

While *Gregg* represents an important victory for defendants and their insurers, the stark division of opinion amongst the Lords means that the issue will need to be revisited. The question is whether that will ultimately be the responsibility of the judges or the politicians.

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[282] Ibid (n 227) per JA Hodgson paragraphs 1-10 discussion of J Gaudron's critique of loss of chance as the gist of a negligence claim in *Naxakis v Western General Hospital* (1999) 197 CLR 269, ats 277-281. J Gaudron suggested that this approach could disadvantage claimants in circumstances where the chance of successful treatment is more than 50%, as they would be paid damages for the lost chance and not the full amount of the lost treatment.

[283] 'Loss of Chance' in I Freckelton and D Mendelson (eds), *Causation in Law and Medicine* (Dartmouth, Ashgate, 2002) 197.

[284] Foster (n 48) 248.

V. CONCLUDING REMARKS ON CAUSATION

> There is no doubt that in academic circles there is disquiet about the current state of the law on causation. I have called this paper 'Causation — The Search for Principle' and I have tried to find the principles. It is not easy. Even when the principles are identified, it can be unclear which principle should be applied to the facts. I feel that barristers and advocates will continue to have difficulty with questions of causation and that the issue will continue to occupy the time of the Court of Appeal as often as it presently does.[285]

What is being referred to by Janet Smith is that there are increasing numbers of cases in which the medical experts express their views on causation in terms of increased statistical risk.[286] Unless and until the courts decide that the particular case falls within the *Fairchild* exception, such evidence will have to be dealt with by the application of the 'but-for' rule. Smith contends that what needs to be understood is that, if the defendant's negligence has more than doubled (a twofold risk) the otherwise existing risk that the claimant will develop the disease, the claimant will succeed because, as a matter of logic, he will have shown that it is more likely that the negligence has caused his disease than that it has been caused by other potential causes.[287] As we have seen, medical experts give evidence in ways not always congruent with legal requirements. And due to the complex nature of the human body and disease, the need to show a twofold risk is a high threshold to require.

The point has been made that the complexity of causation creates a need for greater clarity and depth of analysis.[288] A specific vocabulary of causal terms such as 'cumulative', 'alternative', 'divisible injury', and 'indivisible injury' has emerged, providing for clearer reasoning about the relevance of decided cases. It is not helpful that *Chester*, a case regarding consent, should have been framed along causation lines. The *Fairchild* exception favours employees, while *Wilsher* and *Gregg* put patients' interests behind NHS budgets. The implication of this will be considered in the following chapter on damages.

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[285] Smith (n 113). Stauch (n 67). Case comment *Bailey* (n 68) Green (n 222).
[286] Ibid Smith at 112.
[287] Another example would be if a delay in diagnosis moves a cancer patient's odds of recovery from a good chance of remission – 95% to a 30% chance of remission, the negligence would be seen to be the cause of the damage.
[288] G Turton, 'A Case for Clarity in Causation?' (2009) 17 *Medical Law Review* 1, 140.

An apt summary of the nature and function of the use of the concept of causation in the law is to be found in Tony Honoré's paper 'Causation in the Law'.[289] He sees causation as a multi-purpose tool, one function being 'forward-looking': specifying what will happen, and by what stages, if certain conditions are present together. More applicable to the present discussion are the following two functions:

(1) backward-looking and explanatory: that of showing which earlier conditions best account for some later event or state of affairs and
(2) attributive: that of fixing the extent of responsibility of agents for the outcomes that follow on their agency or intervention in the world.

Many legal inquiries are concerned to explain how some event or state of affairs came about, especially an untoward event such as death. However, in law, the third function of attribution is particularly salient and controversial. Whether someone is liable to punishment or to pay compensation, or is entitled to claim compensation, often depends on showing whether the person potentially liable has caused harm of a sort the law seeks to avoid. When considering causation and legal responsibility, it must be shown that the harm was done or brought about by the agency that the law treats as a potential basis for the existence or extent of liability. The relationship between causing harm and legal responsibility is complex. The complexities concern the incidence of responsibility, the grounds of responsibility, the items between which causal connection must be demonstrated, and the variety of relationships that can in some sense be regarded as causal. Although the question of what the law of negligence is ultimately trying to address deserves a chapter to itself, it is impossible to put it to one side. One can see the law of negligence as embodying the principle of individual responsibility for the consequences of one's actions, as explained by Weinrib:[290]

> The law of negligence involves at the remedial stage a two-fold process. Not merely is the plaintiff compensated but this compensation is extracted from a particular defendant. And this particular defendant is not singled out because of some general moral deficiency, but because of his connection with the injury that has been inflicted.

This is very persuasive as a principle, but when translated into reality one must admit that the concept of personal responsibility (corrective justice) gets somewhat diluted

[289] Honoré (n 141).
[290] Weinrib (n 95).

through the mechanisms of vicarious liability and insurance cover. As noted above,[291] the courts appear to be using the language of cause to decide questions of policy, such as which of the parties is best placed to shift the loss in question (distributive justice). The case law dealing with when the courts are prepared to adopt the *McGhee/Fairchild* principle in overcoming 'evidential gaps' in causation has, not unsurprisingly, been comprised of cases of employee/employer relationships where it is clear that policy decisions of fairness to employees are operating.[292] Conversely, the requirements of proving causation in clinical negligence cases have been seen to be maladaptive. This is so because medicine is as much an art as a science and proving causation has been demonstrated to be an inexact science. Additionally, there is the issue of who pays the defendant's damages, for example the National Health Service or employers.[293] Although it is not a principled idea that commercial employers are seen to be more able to pay damages, it is an underlying consideration that, if found liable, the National Health Service will be diverting money away from patient care.

Nevertheless, there does seem to be a new era dawning in clinical negligence cases with the House of Lords decision empowering patients regarding informed consent in *Chester v Afshar.*[294] The next marker for patients came with the House of Lords' deliberations in *Gregg v Scott,*[295] a 'loss of chance' case. The issue was whether 'loss of chance' could itself become a gist of negligence. The House of Lords in *Gregg v Scott* held, by a majority of two, that the law was, and should remain, that damages for loss of chance should only be forthcoming where the chance of a cure or recovery was over 50%. There was wide-ranging discussion of the issues in the judgment: should medical negligence be like other forms of negligence; how should loss of chance be assessed statistically and could it be fairer; what is the definition of a cure? The judgments, while preserving the status quo, reflect disquiet in the courts that the present system is unjust. Mason and Laurie[296] have noted that there have been significant rulings from the House of Lords that demonstrate well both the power and dangers of policy-driven judicial activism. While a hard line was taken in *Gregg,* it was difficult to reconcile this with the decidedly vague

[291] As noted.
[292] Lord Brooke (n 69) in discussing the *Wilsher* hearing (n 71) quoted Lord Fraser from Scotland, who told him the reason why there were so many cases from Scotland in the 1950s and 1960s which appeared to be doing funny things about causation in industrial disease cases was that the judges were so aghast by conditions in the Scottish factories that they were determined to use tort law to get employers' liability insurers to do something about those conditions. Brooke (n 69) 6.
[293] Are there more favoured defendants?
[294] *Chester* (n 36).
[295] *Gregg* EWCA (n 251).
[296] Mason and Laurie (n 135) 163.

policy appeals of the majority in *Chester*. However, the trend emerging elsewhere is that the courts are bowing to pressure to assist the claimant over the causation hurdle in medico-legal cases.[297]

VI. CONCLUSIONS ON PROVING LIABILITY

In these chapters, collectively, I have considered the question of the onus on the claimant who follows the legal route to redress for iatrogenic harm, in particular, the need to show that the defendant owed him a duty of care; that there was a breach of that duty; and finally that the breach caused the damage complained of. The duty of care determines, as a matter of policy, whether the type of loss suffered by the claimant in the particular manner in which it occurred can ever be actionable. In clinical negligence cases, proving a duty of care is usually not problematic, although there may be issues of timing as to when the duty properly arose. As regards the issue of breach of duty, this concerns setting the requisite standard of care required of a defendant in the circumstances in order to satisfy the duty of care, and whether the defendant's conduct fell below that standard; whether the defendant was careless/negligent.[298] The resolution of this issue depends greatly upon expert evidence, usually medical experts.

A recurring theme throughout the entire thesis is the disparity in the conceptualisation of medico-legal problems between the medical and legal professions. Each profession comes to the problem of the need for legally recognised evidence from a different perspective. Historically, this was particularly tendentious, but hopefully, there is presently a more collaborative climate. As we have seen, these problems are nowhere more evident than in the quest to establish causation. In the event that the claimant is successful, the relief available is damages. In the next chapter, Damages, prior to considering the financial ramifications of the relief, I will look at the philosophical and symbolic meaning of financial compensation for non-pecuniary losses.

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[297] Eg New South Wales (*Rufo v Hosking* (n 227). Mason and Laurie (n 135) 163. As to the applicability of Article 2 (right to life) claims, there are different legal tests and remedies. If a violation of Article 2 might lead to declaratory relief damages, traditional causation rules normally apply. See HRA 1998 s 8: 'No award of damages is to be made unless…the Court is satisfied that the award is necessary to afford just satisfaction to the person in whose favour it is made…the Court must take into account the principles applied by the European Court of Human Rights in relation to the award of compensation under Article 41 of the Convention' (HRA) 1998 s 8 (3) and (4). E Bishop, Paper presented to Butterworth Clinical Negligence Conference, London, 2 July 2009.

[298] Jones (n 38) 85.

CHAPTER 6

DAMAGES
'WHEN SORRY DOESN'T CUT THE MUSTARD'

> I suggest that the crucial controversy in personal injury torts today is not in the area of liability but of damages. Questions of liability have great doctrinal fascination. Questions of damage – and particularly their magnitude – do not lend themselves so easily to discourse. Professors dismiss them airily as matters of trial administration…[1]

[1] L Jaffe, 'Damages for Personal Injury: The Impact of Insurance' (1953) 18 *Law & Contemporary Problems* 219, 221-22, as quoted in S Ingber, 'Rethinking Intangible Injuries' (1985) 73 *California Law Review* 772 at 774.

I. INTRODUCTION[2]

> The question, which our book tries to answer, is not focused on what one could call the 'substantive' part of the law of tort… – on which there is a fair amount of academic discussion, but on the 'remedial' part of tort law which has not been well served by academic literature. Here the questions, in their simplest form, are: 'can the claimant obtain damages for this or that heading of damage?' and, if so, 'how much'?[3]

This is the concluding chapter of the section of the thesis concerned with medical negligence litigation. Researching the earlier chapter on the funding of claims[4] aroused feelings both of interest and dismay at the substantial financial hurdles prospective claimants now face. This chapter on damages[5] is the cornerstone of a thesis concerned with redress for negligently inflicted personal injury in clinical negligence cases. Redress via the legal route will then be contrasted with the possibilities of redress offered through the NHS schemes, which will inform the second part of the thesis.

Selective subjects have been chosen which resonate with issues pertinent to the Health Service. The chapter begins with a discussion of theories of compensation, consideration of what damages are for and what they represent. The choice of model of corrective or distributive justice, deterrence, or retribution determines notions of entitlement to financial redress. This becomes particularly challenging when looking at the heads of claim pertaining to non-pecuniary loss and the use of monetary compensation for intangible losses. I will concentrate on the theoretical and practical difficulties that claims for non-pecuniary loss, namely pain, suffering and loss of amenity, represent. I will then discuss claims for wrongful death which encompass bereavement payments.[6] Having discussed non-pecuniary loss, I will briefly touch on relevant aspects of pecuniary loss. This is followed by a discussion of claims for psychiatric harm and/or injury which encompass both non-pecuniary and pecuniary losses.

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[2] In this chapter, all italicised text is my emphasis unless otherwise explicitly mentioned otherwise.
[3] B Markesinis, M Coester, G Alpa and A Ullstein, *Compensation for Personal Injury in English, German and Italian Law: A Comparative Outline* (Cambridge, Cambridge University Press, 2005), 198.
[4] Chapter 3 'Funding Litigation' above.
[5] Interestingly, in five years of legal studies, two hours were devoted to damages!
[6] As an exception to my argument against payment for non-pecuniary loss, I would keep the bereavement award.

I will argue that in accepting corrective justice as my preferred model, I have no quarrel regarding patients' *entitlement* to full compensation for both pecuniary and non-pecuniary loss. However, mindful that there are compelling competing calls on the NHS budget for treatment from other patients and members of the public, I would limit compensatory damages to pecuniary loss. This is because the NHS is, by its nature, a communal enterprise and the arguments for distributive justice which focus on the just distribution of goods across the population are also legitimate. In addition to this pragmatic argument, there is the theoretical one. Because, by its very nature, non-pecuniary loss is unquantifiable in financial terms, after reviewing academic and judicial attempts to place financial value on these losses in this chapter, I will suggest alternative models for redress for this aspect of claims in the final part of the thesis.[7]

The issue of redress for pecuniary loss is less theoretically challenging but of immense importance to claimants. In the larger picture, a serious crisis looms from the very challenge of tort law, exemplified by clinical negligence claims, as a suitable method of compensating accident victims[8] in the modern welfare state.[9] There have been perceived medical indemnity insurance crises in Australia, New Zealand, the USA and England. I will conclude with a brief review of their legislative responses to this.

In sum, in the previous chapters, I have discussed the difficulties claimants face when trying to mount claims for clinical negligence. In the first chapter[10] I argued that victims of iatrogenic harm have an entitlement to redress based on corrective justice principles. The second chapter[11] canvassed the issue of what victims of iatrogenic harm would want as compensation. In the third chapter[12] I discussed the difficulties of funding litigation, noting in particular the withdrawal of legal aid and future reliance on funding through CFAs. The two subsequent chapters concerned the difficulties claimants face in proving liability.[13] If claimants successfully negotiate their claim, the redress available through the legal route to justice is damages (money). To the extent that money can provide like-for-like compensation, the redress is symmetrical and appropriate.

[7] See Part III Chapter 9 'Effective Redress' below.
[8] For example, patients suffering iatrogenic harm.
[9] C Sappideen and P Vines (eds) *Fleming's The Law of Torts* 10th edn (Australia, Thomson Reuters (Professional) Ltd., 2011) 15.
[10] Chapter 1 'Corrective Justice and Entitlement to Redress Within the NHS'.
[11] Chapter 2 'What do Patients Seek from Redress?'
[12] Chapter 3 'Funding Litigation'.
[13] Chapter 4 'Proving Clinical Negligence: Duty and Breach'; Chapter 5 'Proving Clinical Negligence: Causation'.

However, in the domain of redress for non-pecuniary loss, and confining this argument to the specific case of claims within the English NHS system, I will argue that alternatives to money should be available.

II. SETTING THE SCENE: THEORIES AND PRACTICALITIES OF COMPENSATION

What are damages for? Historically the entire field of tortious liability was divided according to its purposes into criminal, tortious, contractual and restitutionary. Each of these is distinguishable by the nature of the conduct or its consequences and the purpose for which remedies were given. Today, tort liability exists primarily to compensate the victim by compelling the wrongdoer to pay for the damage done. Its paradigm is the conflict between two individuals. The tort of negligence is now dominated by the law of accidents occasioned unintentionally. The law of torts is best seen as a system of corrective and distributive justice. Corrective justice takes the view that where a wrong is done by one person to another it must be corrected by compensation in order to equalise the moral balance between the parties. Distributive justice focuses on the just distribution of goods across a population and thus may cut across the pure corrective justice supposition that the two parties were equal. I have opted for liability and entitlement based on notions of corrective justice but distribution of damages (for non-pecuniary loss) partially based on distributive justice grounds.[14]

The remedy most successful claimants obtain is money damages. Where pecuniary loss is to be considered, the main issue is quantification. This is because one is replacing like with like and money, in this case, can go some way to *restitutio in integrum*. Non-pecuniary loss poses an entirely different problem. Money may compensate for loss of earnings but can neither undo nor offer an equivalent for pain and suffering and distress.[15] The principle of assessment in clinical negligence claims is to value the damage that arises from the negligence as opposed to the damage that the underlying condition which was being treated would have caused in any event without the negligence. This requires expert opinion as to causation and prognosis; and to deal with the hypothetical condition of the claimant had the negligence not occurred; and to expressly state extra, or new, damage resulting from the negligence. In clinical negligence cases the doctor never warrants a cure and is only responsible for the

[14] Sappideen, and Vines (n 9), Chapter 1.
[15] Ibid Chapter 10 Damages.

negligence.[16] I will first address the issues, theoretical and practical regarding general damages: these include all heads of damage incapable of precise mathematical calculation, including pain, suffering and loss of amenity, in other words non-pecuniary loss.

A. Theoretical Constructs in Non-Pecuniary Loss

An important question to keep in mind while reading what follows is the purpose of awarding compensation for intangible injuries.[17] It has been suggested that there are two types of compensation,[18] corresponding to the two fundamentally different ways in which one object can constitute an 'equivalent' for another object which the person has lost, as follows.

In the first type of compensation, *means replacing compensation* is meant to provide people with equivalent means for pursuing the *same ends* (the same as before they suffered the loss, or as they would have pursued had they not suffered the disadvantage). For example, giving someone who has been blinded a sighted amanuensis or someone who has lost a leg an artificial limb.

The second type of compensation might be called *ends–displacing compensation.* The idea here is to compensate people, not by helping them pursue the same ends in some other ways, but rather helping them to pursue some other ends in a way that leaves them subjectively as well off as they were prior to the injury. Giving someone who has suffered bereavement an all-expenses-paid Mediterranean cruise might be an example of this sort of compensation.[19]

The first kind of compensation attempts to provide people with equivalent means to the same end, while the second type attempts to provide them with equivalent satisfactions through different ends. Both standards of compensation insist that people must be made

[16] G Aldous (ed) *Clinical Negligence Claims: A Practical Guide* 2nd edn (London, Chambers of G Aldous QC, 9 Gough Square, 2011) 215.
[17] Ingber (n 1). To clarify: 'The tort system does not purport to redress all material losses, physical or mental. Although an injured party may have a seemingly legitimate claim to compensation, the tort system concerns itself only with 'legally cognisable' losses…Compensation is to be distinguished from restitution.' at 775.
[18] See R Goodin, 'Theories of Compensation' (1989) 9 *Oxford Journal of Legal Studies* 56-75 at 59 for a full exposition of these ideas.
[19] Ibid at 60.

as well off as they would have been, had it not been for the loss for which they are being compensated. With the second type of compensation, however, they will be as well off as they would have been, but *differently* off than they would have been. To achieve the first type of compensation, it is not enough that they somehow or another be made as well off. They must be left *identically* situated with respect to exactly the same set of ends. The weight of the argument is the moral superiority of the first type of compensation, namely, providing equivalent means to pursue the claimant's own pre-accident ends.[20]

In more familiar legal language, pecuniary compensation for pecuniary losses would constitute compensation of the first type, the replacement of like with like. Compensation of a pecuniary nature for losses which were non-pecuniary represents the second type of compensation, the substitution of one sort of pleasure for another.[21] Robert Goodin concludes that tort law, although notionally generous, in practice offers small sums in compensation for non-pecuniary losses.[22] Small sums can hardly pretend to 'make up' for serious bodily harm. They are instead token payments. As with *nominal damages* in tort law, the sums involved are not 'utterly derisory'; but pretty clearly, the principal value of the awards is to be symbolic.[23] The aim, in Patrick Atiyah's terms, is surely to provide 'solace' rather than 'substitutes'.[24]

On another view, 'pain and suffering is essentially the prototype of a non-transferable, non-quantifiable injury'.[25] However, if the claimant's injury is not merely physical and emotional distress but the fact that his distress remains unrecognised and uncompensated, the cost of such an injury is in fact transferable. To the extent that pain and suffering and emotional distress are real injuries, denial of compensation creates the appearance of legal and societal indifference to the victim's plight. An individual whose bodily or emotional integrity has been violated may feel a sense of continuing outrage. Because money is highly valued in our society, we use it to measure and recognise the worth of both tangible and intangible items. Compensation may restore the claimant's

[20] Ibid at 60 also footnote 23 therein. This distinction is also made by Atiyah's 'equivalence compensation' and 'substitute (or solace) compensation'. P Cane, *Atiyah's Accidents, Compensation and the Law* 4th edn (London, Weidenfeld and Nicolson, 1987), 5 now P Cane, *Atiyah's Accidents, Compensation and the Law* 7th edn (Cambridge, Cambridge University Press, 2006).
[21] R Goodin (n 18), 59.
[22] Ibid cites studies at 62.
[23] Ibid quoting G Williams and BA Hepple, *Foundations of the Law of Torts* 2nd edn (London, Butterworth, 1984) 57- 58.
[24] P Cane, *Atiyah's Accidents, Compensation and the Law* Cambridge University Press, 7th edn (2006).
[25] Ingber (n 1) at 774.

sense of self-value, and ease his sense of outrage.[26] From the victim's perspective, compensation becomes not just reimbursement, but an attempt to make amends for the injury done by bestowing a 'consolation, a solatium'. Although monetary damages may not be equivalent to the injury experienced, damages can serve as an important symbolic means of preserving the entitlement of personal security and autonomy against infringement.[27]

The counter-argument challenges the concept of monetary awards for non-pecuniary loss because money cannot provide meaningful compensation to the victim. Society would have acknowledged the victim's right to bodily and emotional security by granting damages for the economic ramifications of his injury – his cost of coping and being rehabilitated. The remaining injury is arguably only that which is truly non-quantifiable and non-transferable and, therefore, best borne by the victim. When this factor is combined with the unique and individualised sensitivity of individuals to physical and emotional pain, meaningful compensation for non-pecuniary losses simply may be impossible. Such damages would neither restore nor rehabilitate.[28]

It is difficult to justify the use of financial resources taken from the NHS budget to make amends for disabilities or loss of faculty, pain and suffering, or death of a close relative. The law can only compensate in financial terms: even though the 'loss' has no measurable financial value, compensation in money can be, and is, given. As I will discuss below the victims of adverse events are not assuaged for these losses by money. I argue that the use of this money to compensate for non-commmodifiable losses highlights the tension between the welfare state, as represented by the NHS, and the tort system.[29]

B. Conceptual Difficulties

The foregoing paragraphs comprised a bald outline of the basis of a claim for general damages.[30] Despite a 'health warning' that 'attempts to deduce radical prescriptive solutions from exchanges conducted at high levels of abstraction must be regarded with

[26] Ibid at 781.
[27] Ibid at 781-782.
[28] Ibid at 784.
[29] Cane (n 24), Chapter 1 for discussion of the disparity of compensation between accident victims and the diseased.
[30] Absent future loss of earnings.

caution',[31] we should nevertheless consider the philosophical foundations of offering financial compensation for non-pecuniary losses.

If one takes as one's starting point that the most fundamental principle governing the award of damages in the law of torts is to restore the claimant to the position where he would have been had the tort not occurred[32] – *restitutio in integrum* – the problem is obvious. By definition, non-pecuniary losses are those for which the payment of monetary damages does no good.[33] This problem has been explained in terms of the non-utility of money in these circumstances[34] or, more emotively, as the 'incommensurability' of money with these types of losses.[35] However, Bruce Chapman offers a slightly different account of what corrective justice requires for the payment of monetary damages.[36] He argues that while corrective justice does require full compensation for the costs of future care (at least in so far as these involve pecuniary losses) and does require full compensation for the loss of future earnings, it does not require full compensation for non-pecuniary loss. He focuses upon the inherent correlativity of the defendant's doing and the claimant's suffering of harm. Chapman reasons that corrective justice should only correct for wrongful losses within the space of rights and that it should not otherwise be concerned with a victim's welfare. Explaining that money damages simply cannot repair the kind of rights damage suffered when losses are of the non-pecuniary kind, he claims that money damages in this context can only serve to increase the victim's welfare in some respect which is irrelevant to the wrongful act. Thus because corrective justice does not support compensation for such losses, he maintains that nominal damages alone are appropriate for this type of loss. According to Chapman the argument for very limited damages for non-pecuniary loss is based upon money's lack of utility – its inability to restore the victim's specific welfare loss within the ambit of the defendant's wrongdoing – a very different matter from how the victim might actually choose to use a monetary award. Chapman distinguishes the idea that money may have no utility in restoring a victim's

[31] H McGregor, *McGregor on Damages* (Sweet & Maxwell, 1997) at 620-621 and footnote 621 now H McGregor, *McGregor on Damages* 18th edn (Sweet & Maxwell, 2010) Chapter 3 'Non-Pecuniary Loss'.
[32] *Livngstone v Rawyards Coal Co.* [1880] 5 AC 25, 39 per Lord Blackburn.
[33] B Chapman, 'Wrongdoing, Welfare and Damages', in D Owen, *Philosophical Foundations of Tort Law* (Oxford, OUP, 1995) 409-425 at 420. Also '*Ex hypothesi*, compensation on this restitutionary basis is impossible in the case of non-pecuniary losses *Restitutio in integrim*, in its ordinary sense, is impossible'. Ogus (n 56) 1.
[34] Chapman (n 33).
[35] M Radin, 'Compensation and Commensurability', (1993) 43 *Duke Law Journal* 56.
[36] Chapman (n 33) at 420.

loss from Margaret Radin's notion,[37] based on her theory of corrective justice as redress rather than rectification, that money may be incommensurate with the victim's loss. Chapman's conclusion, with which I agree, is that the concept of the limited utility of money precludes awarding anything but nominal damages for non-pecuniary loss.[38]

The question then becomes whether or not money can have symbolic value. In place of corrective justice as *rectification*, corrective justice may be seen as *redress*.[39] Redress means showing the victim that his rights are taken seriously:

> Redress is accomplished by affirming that some action is required to symbolize public respect for the existence of certain rights and public recognition of the transgressor's fault in disrespecting those rights. In this conception of compensation, neither the harm to the victim, nor the victim's right not to be harmed, is commensurate with money. They are not conceptually equated with fungible commodities.[40]

On this view, corrective justice as redress provides a way to restore the moral balance between the parties other than by putting the parties back to the *status quo ante*, which may be unachievable, given the fact of incommensurability.[41] Rather, compensation as redress restores moral balance between the parties by simultaneously symbolising, in a non-commodifiable space, a respect for the claimant's rights and a denunciation of the defendant's wrongdoing.[42]

Overall, there are limitations to monetary recompense, particularly in the area of non-pecuniary loss. One can imagine a range of responses to the need for public recognition of wrongdoing which are quite different from the more conventional payment of monetary damages as compensation in tort law. There is a Kantian analysis[43] which suggests that money, while possibly useful to the plaintiff for rectifying the loss, might *not* have much significance for the defendant. In such circumstances, a tort regime which focused more on the defendant's characteristics than on the claimant's loss, and in particular concerned itself with a denunciation of the wrong which was meaningful to

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[37] Ibid.
[38] D Owen, *Philosophical Foundations of Tort Law* (Oxford, OUP, 1995) 21-22.
[39] Radin (n 35).
[40] Ibid 61.
[41] Ibid 69.
[42] Chapman (n 33) at 422. See Apologies below in Conclusions.
[43] I Kant, *The Metaphysical Elements of Justice* John Ladd trans. (1965) 101.

the defendant, might not pay much in monetary damages to the plaintiff.[44] This issue was at the forefront of a conference regarding the draft Corporate Manslaughter Bill.[45] Victims of negligently incurred workplace accidents were as concerned with corporate punishment as with redress. The inclusion in the new Compensation Act 2006[46] of the statement that '…An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty' might offer succour for patients in clinical negligence cases where what is most wished for is an apology from the medical team concerned.

In the final chapter to my thesis I will be discussing recent initiatives in Australia regarding apologies in the sphere of clinical negligence.[47] The next question to be addressed is the approach to quantifying damages for non-pecuniary losses.

C. Putting a Price on Pain and Suffering: Theoretical Issues of Quantification

There is evidence that since biblical times, sages have grappled with the issue of quantification of damages for non-pecuniary losses:

> Loss of time: the injured person is considered as if he were a watchman of cucumber beds. You might say that the requirements of justice suffer thereby, since when he was well he would surely not necessarily have worked as a watchman of cucumbers[48]. But in truth the requirements of justice do not suffer, for he has already been paid for the value of his hand or the value of his leg…[49]

A timely article reviewing the current situation has pointed out that there is still much work to do:[50]

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[44] Chapman (n 33) at 424.
[45] Corporate Manslaughter Conference, London, 13 June 2006. Now the Corporate Manslaughter and Corporate Homicide Act 2007.
[46] Compensation Act 2006 s.2: Apologies, Offers of Treatment or Redress.
[47] Chapter 9 'Effective Redress' below.
[48] meaning he might have commanded higher wages.
[49]Babylonian Talmud: *Baba Kamma* 85 Discussion continues regarding payment for 'Pain and Degradation'.
[50] R Avraham, 'Putting a Price on Pain-And-Suffering Damages: A Critique of the Current Approaches and a Preliminary Proposal for Change' 2006, 100 *Northwestern University Law Review* 87. This article has extensive references, including: RR Bovbjerg, F Sloan & JF Blumstein, 'Valuing Life and Limb in Tort: Scheduling Pain and Suffering', (1989) 83 *Northwestern University Law Review* 908 [Referred to as BSB, Valuing Life and Limb]. Cited in 147 law reviews, 15 other journals and 4 legal news articles, as well as in 5 cases.

> Seventeen volumes and seventeen years ago, the editors of the *Northwestern University Law Review* made a wise decision. They accepted for publication an article – *Valuing Life and Limb in Tort: Scheduling Pain-and-Suffering* – which has become one of the most important pieces concerning pain-and-suffering damages in the legal literature. In what was considered a seminal paper concerning 'putting a price on pain-and-suffering damages' the authors took upon themselves a daunting task: analysing various ways to put a price on the unpriceable, a person's pain and suffering. Nothing much has changed since the BSB paper. Juries, judges, lawyers and academics still struggle with the same dilemma BSB tackled: what is the best way to adequately compensate tort victims for the non-economic harms they incur? In many ways, the BSB paper is as relevant today as it was 'seventeen volumes ago'.[51]

Looking at the picture in England, the levels of awards for pain, suffering and loss of amenity have become an increasingly important issue over the past 20 years.[52] What follows is a concise look at different conceptualisations which inform the approach to quantification; the ideas put forward by the Law Commission in several reports,[53] the judgments in *Heil v Rankin,*[54] and how the final calculations are made.[55] It has been suggested that there are three theoretical approaches to the problem.[56]

First there is the conceptual approach[57] ('so much for a foot') which is objective and has its analogy in the law of property. Each asset, be it physical or the enjoyment of an amenity, bears an objective 'value' which is fully recoverable in the case of loss. This approach requires, in effect, that resort be had to a tariff system which would prescribe a certain 'sum' for each part of the body and for the extent of injury to each part. This method of compensation was in force over 1,000 years ago in the laws of King Alfred.[58] This theoretical approach may be summarised by saying that the award is measured by the extent of the *physical injury*. In support of the suggestion that English law is most

[51] The Court of Appeal in *Ward v James* [1966] 1 QB 273 at 299-300 ruled that juries should no longer be used for the assessment of damages save in exceptional cases. See Supreme Court Act 1981 s. 69(3). For historical overview of juries in personal injury actions see Markesinis et al (n 3), 8-10.
[52] Markesinis et al (n 3), 48.
[53] 'Damages for Personal Injury: Non-Pecuniary Loss' (1995) *Law Com* No 140. 'Damages for Personal Injury: Non-Pecuniary Loss' (1999) *Law Com* No 257 especially paragraphs 2.19 and 2.24. 'Personal Injury Compensation: How Much Is Enough?' (1994) *Law Com* No 225.
[54] *Heil v Rankin* [2001] QB 272
[55] McGregor (1997) (n 31), H McGregor, *McGregor on Damages* (Sweet & Maxwell, 2003) now McGregor (2010) (n 31) 35-287.
[56] AI Ogus, 'Damages for Lost Amenities: For a Foot, A Feeling or a Function? (1972) 35 *Modern Law Review* 1 at 2 ('so much for a foot').
[57] See Sellers LJ in *Wise v Kaye* [1962] 1 Q.B. 638, 644-654 and Lord Morris in *West v Shepherd* [1964] AC 326, 344-353. The English law on the assessment for loss of amenities is not perfectly consistent with any of these approaches, but it has a strong leaning towards the conceptual approach. Ibid at 3.
[58] B Thorpe, *Ancient Laws and Institutes of England*, (London: George E. Eyre and Andrew Spottiswoode, 1840. Reprinted 2004 by The Lawbook Exchange, Ltd.) pp 93-101. Specimen examples of the 'bot' payable: broken arm above the elbow, 15 s: loss of thumb, 30 s: loss of arm below the elbow, 80 s. In Ogus (n 56) at 2.

closely aligned to this conceptualisation, it should be noted that judges in personal injury cases consult Kemp & Kemp for the figures appropriate to the physical damage.[59] The second, personal, approach rejects the premise that human life can be 'valued' independently of an individual's feelings.[60] It suggests measurement can only be made in terms of human happiness; therefore, the award would be measured by the extent of the loss of happiness seen subjectively. The third, functional, approach[61] adopts the premise of the personal approach, that the sole concern of the court is with the claimant's pleasure or happiness, but it prescribes a different standard of compensation. In this approach the award is measured by the extent to which money can provide the claimant with reasonable solace.

The principles behind awarding damages for pain, suffering and loss of amenity, and the issue of quantification have been thoroughly canvassed by the Law Commission.[62]

The Law Commission[63] contrasted the 'diminution of value' approach[64] to the 'functional approach'[65] assessment of damages for non-pecuniary loss. In brief, the conclusion of the Law Commission[66] was to favour the 'diminution of value' approach. The reason suggested is that the 'functional approach' would seem to transform the non-pecuniary consequences of injury into a form of pecuniary loss. Damages for pain, suffering and loss of amenity would be measurable in terms of the financial cost of providing reasonable substitute pleasures to comfort the claimant. Additionally, and more tellingly, it is unrealistic to assume that substitute pleasures can provide full solace to a claimant.[67]

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[59] Ogus (n 56) at 3. Also see W Norris, C Cory-Wright and P Andrews (eds) *Kemp & Kemp: Quantum of Damages* Looseleaf 4th edn Annual Subscription ISBN 9780421216808 (Sweet & Maxwell Ltd, latest release August 22, 2011).
[60] See Ogus (n 56) at 3 for references.
[61] Ibid at 3 footnote 12 for references especially the Australian High Court Judge Windeyer J. *Skelton v Collins* [1966] CLR 94, 130-133 ('so much for a function'). *Law Comm* 140 (n 53) suggests that 'the experience in Canada has not been a happy one'. In particular, most judges have continued to apply a tariff approach to assessment; there is therefore an inconsistency between the rationale for the award of damages for non-pecuniary loss, as authentically laid down by the Supreme Court, and the continued practice of many courts.' Para 4.9 (v) at 85.
[62] *Law Com* 140 (n 53), *Law Com* 257 (n 53), especially paras 2.19 and 2.24.
[63] (The conceptual approach) *Law Com* 140 (n 53) at 8 para 2.3, which quotes from Ogus (n 56) 1 above. *Law Com* 257 (n 53) especially paras 2.19 and 2.24.
[64] The approach used in the English courts.
[65] Used in Canada *Law Com* 140 (n 53) at 83 para 4.8.
[66] Ibid and in the final recommendation in *Law Com* 257 (n 53) 5.2.
[67] *Law Com* 140 (n 53) at 84 para 4.8. See full references cited.

In the English approach, the purpose of an award of damages is to put a value on what the plaintiff has lost, irrespective of the use to which the damages may be put.[68] English law regards both subjective loss (loss which is dependent on the claimant's awareness of it) and objective loss (loss which is not dependent on the claimant's awareness of it) as compensable.[69]

Although I will be arguing against financial redress for non-pecuniary loss within the context of iatrogenic harm within the NHS, I am sympathetic to the diminution of value approach taken by the Law Commission.[70] The main reason for taking this stance is that I believe that non-pecuniary losses are uncommodifiable;[71] additionally, substitute pleasures do not make up for all the non-pecuniary effects of personal injury. Having discussed the theoretical issues of quantification of non-pecuniary losses, I now turn to the difficult but practical issue of quantification of non-pecuniary loss and how the courts have approached this.[72] I will also note the approach to redress for non-pecuniary loss taken by other jurisdictions.[73]

D. Practical Issues of Quantification of Redress for Non-Pecuniary Loss

The difficulties inherent in this head of claim are immediately apparent. In the forward to the first edition of the Judicial Studies Board Guidelines, Lord Donaldson stated that the assessment of general damages for pain, suffering and loss of amenity is 'one of the most difficult tasks' a judge in a civil court has to perform.[74] There is no process of calculation for this head of damage. How is the level of damages assessed for someone who, for instance, loses a finger, or is blinded as a result of an accident? The courts have

[68] Ibid at 8 footnote 9.
[69] Ibid at 8 at paragraph 2.3.
[70] *Law Com* 257 (n 53) para 2.4.
[71] See Radin (n 35).
[72] Section D immediately below.
[73] I will return to this subject in the final Chapter 9 'Effective Redress'.
[74] Great Britain Judicial Studies Board, *Guidelines for the Assessment of General Damages in Personal Injury Cases* (Oxford, Blackstone Press, 1992) (Now 10th edn, 2010). The need for consistency and comparability in awards, previously found wanting in jury trials, led the Court of Appeal in *Ward v James* (n 51) to rule that juries should no longer be used for the assessment of damages save in very exceptional cases. S 69(1) of the Supreme Court Act 1981, which grants a *prima facie* right to a jury trial in cases of fraud, malicious prosecution, false imprisonment and defamation. However, s 69(3) has been seen as strengthening the presumption against jury trial. See Markesinis et al (n 3), 8-9.

looked for a pragmatic solution[75] and have sought to arrive at a 'conventional figure' derived from experience and from awards in comparable cases.[76]

1. Principles of Assessment: Pain and Suffering[77]

The effects of an accident on a claimant are extremely unlikely to be only financial. Impairment, disfigurement, loss of function and pain are just some of the potential non-pecuniary consequences, none of which can be measured in purely financial terms. *Restitutio in integrum* cannot be effected by money if the claimant has lost an arm, or is unconscious. Nevertheless, the courts have never doubted the appropriateness of making awards for the non-pecuniary losses suffered by the claimant; they are, after all the essential losses, the most immediate consequences of the accident.[78] The two main aspects of non-pecuniary loss are pain and suffering (viewed subjectively) and loss of amenity (viewed objectively).

Pain and suffering are combined into a single head and it is inappropriate to separate them in making an award. Damages are awarded for pain which the claimant feels consequent to an injury, both in the past and into the future. The level of damages will depend upon the duration and intensity of the pain and suffering.[79]

In *Hicks and another v Chief Constable of the South Yorkshire Police*[80] on the question of finding whether the deceased suffered compensatable pain and suffering before a fatal injury:

> The trial judge dismissed the action on the ground that the plaintiffs had failed to prove that the deceased had suffered any recoverable damage from pre-death pain and suffering. The plaintiffs appealed to the Court of Appeal, which upheld the judge's finding that no physical injury had been caused before the fatal crushing, on the ground that, since the unconsciousness and death had occurred in such a very short space of time after the onset of asphyxia, the asphyxia and

[75] Diplock LJ in *Every v Miles* [1964] unreported, Court of Appeal.
[76] Lord Diplock in *Wright v British Railways Board* [1983] 2 AC 773 as quoted in S Allen, I Bowley and H Davies, APIL *Guide to Damages* (Bristol, Jordan Publishing Limited, 2004) at 1.
[77] S Allen, I Bowley and H Davies, APIL *Guide to Damages* (Bristol, Jordan Publishing Limited, 2004) at 1-3. See also McGregor (2010) (n 31). '"Pain and suffering" is now a term of art, so constantly has it been used by the courts and there appears to be no exact difference between pain on the one hand and suffering on the other…' Chapter 3 at 3-003.
[78] D Allen, *Damages in Tort* (Sweet & Maxwell, 2000) at 244.
[79] Allen, Bowley and Davies (n 76).
[80] *Hicks and another v Chief Constable of the South Yorkshire Police* [1992] 2 All ER 65, 8 BMLR.

> death were in reality part of the death itself, with the result that no damages were recoverable for that pain and suffering.[81]

If the claimant is unconscious[82] or killed instantly as a result of an accident, there will be no damages under this head, although they may be recoverable for loss of amenity (ie for persistent vegetative state).[83]

The assessment is subjective and it is for the claimant to give evidence of the effects of the injuries. This assessment is made at the date of the trial in order to provide the court with as full a picture as possible resulting in an award of damages in the money of the day.[84]

Suffering is treated as distinct from pain. But the term 'suffering' is meant to cover the mental element of the injury, including the claimant's anxiety, fear, worry, distress and embarrassment caused by the injuries suffered in the accident.

2. Loss of Amenity

Damages are awarded for the reduction in the ability of the claimant to perform every-day tasks and enjoy life, and it does not matter whether the claimant is conscious of the effect upon his life. It can include interference with hobbies and pastimes, loss of a skill or craft, a reduction in marriage prospects[85] and loss of enjoyment of a holiday,[86] or interference with the claimant's sex life.[87]

One problem which has caused much trouble is that of assessing the damages awardable to a claimant who has been reduced to a 'persistent vegetative state'. Medical science can now keep people with the most devastating injuries alive in a state of complete coma for many months, or even years, with no hope of recovery. In a case of this nature it is hard to see what purpose there can be in awarding lump sum damages for

[81] Ibid. Upheld by the House of Lords, Lord Bridge gave the leading judgement. Reading the full case, this seems a cruel outcome.
[82] '…however caused, whether by the injury itself or produced by drugs or anaesthetics…'per Lord Devlin in *H. West & Sons Ltd v Shephard* [1964] AC 326 at 354.
[83] A great deal depends on the current state of medical knowledge. See new information regarding the consciousness of patients in persistent vegetative states: The Guardian 3 February 10 2010.
[84] Allen, Bowley and Davies (n 76).
[85] *Moriaty v McCarthy* [1978] 1 WLR 155.
[86] *Ichard v Frangoulis* [1977] 2 All ER 461.
[87] *Cook v JL Kier & Co* [1970] 1 WLR.

disabilities or loss of amenities, or even for loss of earnings if there are no dependants. There is no question of providing substitute pleasures for those foregone, because the injured party is unable to enjoy any pleasures; nor is there any question of providing solace for pain, suffering or mental distress, because the victim feels none.[88] Nevertheless, the courts have held that although damages for pain and suffering cannot be awarded, nonetheless, damages for loss of 'amenities' or 'faculties' must be awarded; and these damages run into many thousands of pounds.[89]

In *H West & Sons Ltd v Shephard*[90] the majority of the House of Lords confirmed the majority decision of the Court of Appeal in *Wise v Kaye* [91] and held that an unconscious claimant was able to be awarded damages for loss of amenity despite his unawareness of the loss. The essential rationale for this view can be found in the words of Lord Morris:

> The fact of unconsciousness does not, however, eliminate the actuality of the deprivations of the ordinary experiences and amenities of life which may be the inevitable result of some physical injury.[92]

This majority view of the House of Lords in *H West & Sons Ltd v Shephard*[93] was reaffirmed in *Lim Poh v Camden and Islington Area Health Authority,*[94] where Lord Scarman said that the cases draw a clear distinction between the damages for pain and suffering and damages for loss of amenity. The former depend upon the claimant's personal awareness of pain, her capacity for suffering. But the latter are awarded for the fact of deprivation – a substantial loss, whether the claimant is aware of it or not.[95]

The Law Commission, in its Consultation Paper on non-pecuniary loss,[96] suggested that non-pecuniary losses should be assessed subjectively, contrary to the view of the House of Lords in *H West & Sons Ltd v Shephard.*[97] A significant majority of consultees, however, preferred the *status quo*, on the basis that failure to recognise the loss of

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[88] Cane (n 24), Chapter 6.
[89] Ibid at 141.
[90] *H West & Sons Ltd v Shephard* [1964] AC 326. The House of Lords reaffirmed this approach in *Lim Poh Choo v Camden and Islington Area Health Authority* [1980] AC 174.
[91] *Wise v Kaye* [1962] 1 QB 638.
[92] *H West & Sons Ltd v Shephard* [1964] AC 326 at 349.
[93] Ibid.
[94] *Lim Poh v Camden and Islington Area Health Authority* [1980] AC 174.
[95] Markesinis et al (n 3), 48.
[96] *Law Com* 140 (n 53) 2.14.
[97] *H West & Sons Ltd v Shephard* [1964] AC 326.

amenity would be to undervalue victims and to trivialise their experience, that it would be unjust to award lower compensation for major injuries than for lesser ones, and that there might be problems in determining the degree of awareness of deprivation.[98] In the light of this, the Law Commission did not recommend any change in the law on this point.[99]

In both cases, awards for pain and suffering and awards for loss of amenity, the calculation of damages is, to a very large extent, arbitrary. Something which cannot be measured in money is 'lost', and the award of damages requires some monetary value to be placed on it. There appears to be no way of working out any relationship between the value of money – what it will buy – and damages awarded for pain, suffering and loss of amenity. All such awards could be multiplied or divided by two overnight and they would be just as defensible or indefensible as they are today.[100]

3. Evidence

As with all heads of damages, but perhaps more importantly with damages for pain, suffering and loss of amenity, it is imperative that the claimant's statement describes life before the accident or injury and life afterwards. The contrast between his capability and enjoyment of life before and the limitations and restrictions endured and which he may continue to endure following the accident or injury is critical in providing the judge with a true picture of the impact of the injuries on the claimant.[101]

E. Non-Pecuniary Loss: The View from Abroad

As I have shown, non-pecuniary loss poses an entirely different problem from pecuniary loss. Money may compensate for loss of earnings but can neither undo nor offer an equivalent for pain and distress. For the victim, the most money can offer is solace, by providing the victim with the means of distraction and substitute activities, and bringing about some satisfaction in the face of having been wronged.[102] The scale of non-

[98] *Law Com* 257 (n 53) paras 2.8-2.19.
[99] Allen (n 78) at 246.
[100] Ogus (n 56) 1. See also *Judicial Studies Board* (n 74). Maximum award (General Damages) for those of greatest severity is now £257,750. A Tettenborn, (ed) *The Law of Damages* 2nd edn (London, LexisNexis Butterworths, 2010) at 712.
[101] Allen, Bowley and Davies (n 76). See also *Judicial Studies Board* (n 74) and Tettenborn Ibid.
[102] Supported by those primarily concerned with corrective justice. Sappideen, and Vines (n 9), 276.

pecuniary damages should not be underestimated, since in many countries they account for more than half of the total amount paid out under the present tort system. I would not be alone in advocating non-financial payment of non-pecuniary loss, particularly in cases of iatrogenic harm within the NHS. In the absence of any logical process for assessing damages for 'pain and suffering and loss of amenity' jurisdictions have adopted different approaches. As long ago as 1978, the British Pearson Committee advocated limiting awards for non-pecuniary loss.[103] Courts, and sometimes legislatures, have taken steps both to contain and to standardise non-pecuniary loss awards while also attempting to respond to what is 'fair and equitable'.[104] More recently, statutory schemes have been adopted to address this problem: restrictions include thresholds, caps and schedules.[105] I will return to initiatives of other jurisdictions in the final chapter addressing effective redress.[106] The desire to restrict the award of non-pecuniary damages is driven in part by concern that insurers and corporate defendants, and in this case the NHS, may find it increasingly difficult to shoulder catastrophic losses involving multiple victims which occur more frequently with growing technology. One solution is to impose a maximum monetary limit on liability for any one disaster such as products (pharmaceutical) liability. In the last resort, extraordinary intervention by government is required to settle peculiarly costly catastrophes.[107]

I have argued for a modified model of corrective justice when addressing redress for iatrogenic harm, namely that victims have an entitlement to redress against the wrongdoer, in this case the NHS. However, because the NHS is a communal enterprise, I have argued that damages should be limited to redress for pecuniary loss. In order to explain my stance on non-pecuniary loss, I then considered the theoretical and practical difficulties inherent in the quantification of such loss. I now turn to examples of actions which have a major component of non-pecuniary loss: first wrongful death actions and then claims for psychiatric harm.

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[103] *Pearson*, 389 (excluding first three months) Sappideen, and Vines (n 9), 18.
[104] *Pickett v British Rail* [1980] AC 136 at 168 (Lord Scarman).
[105] See Sappideen, and Vines (n 9), Chapter 10 at 278-284 for details of initiatives in Canada, New South Wales, Victoria and the United States.
[106] Chapter 9 below.
[107] Sappideen and Vines (n 9) at 284. This occurred in Britain and Germany over the Thalidomide disaster. For recent discussion see P Sparks, 'Revisiting the Case for Uplifting Damages for Non-Pecuniary Loss' (2011) 1 *Journal of Personal Injury Law* 6-9 "In the current economic climate there may be less public support for reforms which increase the burden on the NHS resources…" at 9.

III. DAMAGES IN RESPECT OF DEATH

In wrongful death actions, there is a complex interaction between claims by the estate of the deceased (for example, for pre-death pain and suffering) and those of dependants under the Fatal Accidents Act 1976. The bereavement award discussed below[108] is a one-off payment to a narrowly defined class of claimant. Although it is admittedly for a non-pecuniary loss, I would allow this payment because it is a conventional sum which has historically been paid and by now has a strong symbolic value.[109] I will note how other jurisdictions[110] have grappled with the issue of damages for bereavement.

There are two separate and distinct claims which may be brought in respect of the death of a person as a result of some tortious act of the defendant:

(a) The claim on behalf of the deceased's estate (Law Reform (Miscellaneous Provisions) Act 1934) and

(b) The claim brought by the deceased's dependents in respect of their own loss (Fatal Accidents Act 1976 (as amended)).[111]

A. The Survival Action

Historically, at common law there could be no claim for damages in cases of death. This was, in part, a consequence of the maxim: *action personalis mortur cum persona,*[112] and in part a result of the rule expressed in *Baker v Bolton*[113] that death does not comprise an injury for the purposes of a civil action. Statute subsequently ameliorated the position. As regards the former maxim, the Law Reform (Miscellaneous Provisions) Act 1934 enables the right of action of an injured person to survive his death, it being passed on to his personal representatives.[114] A deceased's claim survives for *the benefit of the estate* regardless of whether the *death* was caused by the defendants' breach of duty/negligence.[115] Heads of damage usually include:

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[108] Section B (2) below.
[109] Tettenborn (n 100) at 869.
[110] Scotland, Australia and France.
[111] Allen, Bowley and Davies (n 76) at 81.
[112] "A cause of action dies with the person" in Allen (n 78) at 259.
[113] *Baker v Bolton* (1808) 1 Camp. 493.
[114] Allen (n 78) at 259.
[115] Allen, Bowley and Davies (n 76) at 81.

(i) non-pecuniary loss: pain and suffering; and

(ii) pecuniary loss: past loss of earnings; past care and services; miscellaneous losses including medical expenses, travel and probate.

Claims may include damages in respect of funeral expenses.[116] A claimant may have suffered an injury that reduces his life expectancy, resulting in a loss of potential earnings or pension he would otherwise have received in the lost years. A living claimant may recover damages for these losses but this head of damages does not survive for the benefit of the estate. A claim for pain and suffering, as has been noted,[117] is calculated in accordance with conventional principles and is therefore dependent upon the claimant's personal awareness of pain and suffering.[118]

The practical significance of the rule in *Baker v Bolton*[119] that death does not comprise an injury for the purposes of a civil suit has diminished significantly in recent years and the most important piece of legislation is the Fatal Accidents Act 1976, a consolidation of earlier legislation originating in the Fatal Accidents Act 1846 and amended by the Administration of Justice Act 1982.

B. The Dependency Action

Under the Fatal Accidents Act claim, a right of action is conferred on the dependants of the deceased, reflecting their loss, not his. This action is primarily designed to provide compensation for the lost income of a person who was formerly maintaining members of their family, normally a spouse or cohabiting partner and children. The action provides compensation not only for an actual dependant but also for a prospective dependant, so long as the claimant falls within the list of persons entitled to sue under

[116] Funeral expenses usually form part of the Fatal Accidents Act claim if the dependants have incurred the expense. However, in *Bateman v Hydro Agri (UK) LTD.* [1995] unreported, the judge held that the claimant, who was suffering from mesothelioma and was expected to die within 3 months, could recover the prospective costs of his funeral. Allen, Bowley and Davies (n 76) at 82. For the scope of what may properly be included as funeral expenses see McGregor (2003) (n 55), 540 now McGregor (2010) (n 31).
[117] Above: Principles of Assessment (p 219) *Hicks v Chief Constable of South Yorkshire* [1992] 2 All ER 65, HL 'an attempt by the estates of the victims to recover damages on this basis failed on the facts: it being found that no actionable pre-death pain and suffering had occurred.' McGregor (2003) (n 55), 520 now McGregor (2010) (n 31).
[118] *Lim Poh Choo v Camden and Islington Health Authority* [1980] AC 174 at 183 and *Hicks and another* (n 80)
[119] *Baker v Bolton* [1808] 1 Camp 493.

the Act. Thus a parent may be able to sue in respect of the death (say) of a child of 16 who has not yet contributed anything to the parent's support but who might have been expected to in the future. The crucial matter of note is that although this claim is that of dependants, not the deceased, they can only claim if he would have been able to, had he survived.[120]

In claims on behalf of dependants, the heads of damage usually include: [121]

1. Damages in respect of bereavement
2. Damages for loss of dependency and
3. Funeral expenses.[122]

The question of who can claim as a dependant is one involving issues of law and fact. Any claim under the Act has to be brought by the executor or administrator of the deceased; but may be brought by the dependants themselves six months after the death, if no action has been brought by then. It is noteworthy that only one action can be brought[123] and full particulars of the persons for whose benefit the action is brought must be given.[124] However, although only one Fatal Accidents Act action can be brought in respect of the death, each dependant is nevertheless individually entitled to his own damages.[125]

The Act contains a detailed definition of persons whose relationship with the deceased was such as to enable them, as a matter of law, to qualify as dependants but they must, in addition, satisfy the factual test of establishing whether they had, in the words of one of the leading authorities,[126] 'a reasonable expectation of pecuniary benefit, as of right or otherwise, from the continuance of the life'.[127] In its 1999 Report: 'Claims for Wrongful Death',[128] the Law Commission recommended retention of the present list of

[120] Allen (n 78) at 259 for case law.
[121] Fatal Accidents Act 1976, s 2(1).
[122] Allen, Bowley and Davies (n 76) at 83.
[123] Fatal Accidents Act 1976, s 2(3).
[124] Fatal Accidents Act 1976, s 2(4).
[125] See McGregor (2003) (55), ch 26 for details of calculation and apportionment of the dependency.
[126] *Franklin v South Eastern Railway Co.* [1858] 3 H & N 211 at 214 quoted in Allen (n 78) at 261.
[127] Ibid at 261 for the list of who can be a dependant as a matter of law. See Fatal Accidents Act 1976 s.1 for the original list; now expanded in Fatal Accidents Act 1976, s.1 (3)(b).
[128] Law Commission 'Claims for Wrongful Death' (1999) *Law Com* No 263 paragraph 3.46.

those able to claim, but regarded it as too restrictive.[129] It is important to note that, subject to the statutory award for bereavement to be considered below, damages under the Fatal Accidents Act 1976 are restricted to pecuniary losses.[130]

An apposite clinical negligence case illustrates how these two Acts work together:

> In *Batt v Highgate Private Hospital*[131] the claimant was the widower of Lorraine Alison Batt who died on 30 January 1999 following an abdominoplasty. This is a cosmetic operation, more commonly referred to as a "tummy tuck". There were devastating post-operative complications. As a result, her life was taken away from her at the age of 36. She left behind her husband, two teenage children of a previous marriage and a daughter of 7 from this one. Judgment was entered against the surgeon who performed the operation on 21 November 2003. The matter came before the court for the assessment of damages.

The widower Batt sought damages for the death of his wife. Two unusual heads of damage were claimed. Under the Law Reform (Miscellaneous Provision) Act 1934, Batt sought repayment of the £5,635 cost of the operation, arguing that the expense was rendered futile by his wife's death and she received no benefit from it. He also claimed £116,000 under the Fatal Accidents Act 1976, for the loss of an appreciating asset in the form of a house which he and his wife were in the process of buying before she died.

Assessing damages, Darlow J held that Batt could not claim for either loss because the first, the cost of the operation, did not flow from the negligence of the surgeon and expenses rendered futile by a tort did not have the same importance in tort as they had in contract. The second, under section 3 of the Fatal Accidents Act 1976, Batt could only recover for a loss of a pecuniary benefit arising from the relationship which would be derived from the continuance of life. This meant that the dependency claim was limited to what had been lost as a result of the wife's ceasing to contribute to the family finances, plus the loss of her gratuitous care of the couple's daughter.[132] Batt was attempting to claim for the loss of a speculative gain arising from the use of family

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[129] Allen (n 78) at 262 for fuller discussion and case law. See also K Norrie, 'Rushed Law and Wrongful Death', 51 *Journal of the Law Society of Scotland* 4, 24 for adjustment of s 35 Damages (Scotland Act) 1976 changing and expanding the list of those with 'title to sue for Non-Patrimonial Loss'.
[130] *Blake v Midland Railway Co.* [1852] 18 QB 93.
[131] *Batt v Highgate Private Hospital* [2004] EWHC 707, CH D (Patents). S King, Case Commentary: 'Personal Injury; Clinical Negligence; Damages; Fatal Accidents Act' (2004) 4 *Journal of Personal Injury Law* C169-173.
[132] Ibid for full discussion of the case. Refer also to D Kemp, 'Substitute Services and the Fatal Accidents Act' 1993 (APR) *Law Quarterly Review* 109, 173-175 regarding calculations of 'substitute services' and the value of a parental care.

funds to acquire a capital asset. Furthermore, the increase in the house's value from £94,000 to £210,000, its value as at January 2004, was not a result of her death. In other respects, damages were awarded on the usual basis.

1. Calculating the Dependency

As has been seen, the claim under the Fatal Accidents Act 1976 is restricted to recovery of pecuniary losses only. The principle is that if the patient has died, damages awarded to his family will reflect the loss to them of the moneys he regularly expended on them. They recover for their loss of dependency.[133] The precise method of calculation for pecuniary losses is outwith the remit of this thesis[134] but a few comments might be helpful. The calculation of awards of damages for personal injury is notoriously imprecise, particularly when attempting to place a value on future losses. In cases where the claim comprises a specific loss, such as the contribution to wedding expenses in *Betney,*[135] the calculation is a simple one. Where the dependency is a continuing one, the matter is more complex.[136] As with personal injury cases, a multiplier/multiplicand method is employed, the multiplicand being the present annual value of the dependency, the multiplier being the likely duration of the dependency, subject to being discounted to take account of the fact that the dependant is receiving an immediate lump sum rather than periodical payments over a period of years, as would have been the case had the deceased lived.[137] In addition, the contingencies of life will be taken into account in determining the multiplier.[138]

[133]Fatal Accidents Act 1976 as amended by the Administration of Justice Act 1982. M Brazier, and E Cave, Medicine, Patients and The Law, 5th edn (Harmondsworth, Penguin, 2011) at 233.
[134] Allen (n 78) ch 10; Allen, Bowley and Davies (n 76), ch 13 and McGregor (2003) (n 55) ch 26 for calculations of damages.
[135] *Betney v Rowland and Mallard* [1955] 2 All ER 166.
[136] Death statutes in the United States list elements of loss for which a defendant must make compensatory payment. The element that economists as expert witnesses are called upon to calculate is net income interpreted as the money required for survivors to attain the same standard of living as before. Equivalence scales traditionally used for these calculations are flawed. The author proposes a new method of calculation. A Lewbel, 'Calculating Compensation in Cases of Wrongful Death' (March 2003) 113 *Journal of Econometrics* 1, 115-128.
[137] Since the decision of the House of Lords in *Wells v Wells* [1998] 3 All ER 481 actuarial tables provide the basis for the selection of multipliers in Fatal Accident Act cases just as they do in personal injury cases. See McGregor (2003) (n 55), 528 paragraph 26.20 footnote 2 now McGregor (2010) (n 31). See also below 'Methods of Payment: Periodical Payments.'
[138] Allen (n 78) ch 10 at 264 and McGregor (2003) (n 55) ch 26 for examples of contingencies taken into account. Now McGregor (2010) (n 31).

2. Damages for Non-Pecuniary Loss in Respect of Bereavement: Who Can Claim and in what Amount? – Judicial and Legislative Initiatives

Although admittedly, damages in respect of bereavement represent payment for non-pecuniary loss, I would not disallow this. As the award is a conventional sum, it represents an acknowledgement of loss and by now has a symbolic significance. It does not represent a large sum, as the standard award is small, and removing it would cause offence beyond what the saving would merit. That said, it is acknowledged that 'non-pecuniary damages are essentially arbitrary in nature, lacking the objectivity found in the case of pecuniary losses'.[139] I will set out the law in England and then briefly note the position of several jurisdictions regarding bereavement awards. Although there is unease in all the jurisdictions about this payment, expressed partly by limitations on the class of claimants, none have removed it completely.

It was established as long ago as 1852[140] that the claim under the Fatal Accidents Act is restricted to recovery of pecuniary losses only, subject only to the introduction in 1982[141] of a statutory claim for damages for bereavement in a limited class of cases. Those entitled to claim are the wife or the husband of the deceased and, where the deceased was a minor who never married, his parents, if he was legitimate, and his mother, if he was illegitimate. The bereavement award is a fixed sum. The specified amount recoverable was initially £3,500 but was raised to £7,500 in respect of deaths occurring on or after 1 April, 1991.[142] In respect of deaths on or after 1 April 2002, the amount was £10,000[143] and in respect of deaths on or after 1 January 2008, it is now £11,800.[144] As can be seen, the range of claimants is very much narrower than that for claimants for loss of dependency under section 1 of the Act. In its 1999 Report 'Claims for Wrongful Death',[145] the Law Commission recommended a significant extension to the statutory list.[146]

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[139]Markesinis et al (n 3), 223.
[140] In *Blake v Midland Railway Co.* [1852] 18 Q.B. 93.
[141] S 1A of the 'Fatal Accidents Act 1976', as inserted by s 3(1) of the 'Administration of Justice Act 1982'.
[142] Law Reform (Miscellaneous Provisions) Act 1934, s 1(1A).
[143] Damages for Bereavement (Variation of Sum) (England and Wales) Order 2002, SI2002/644.
[144] The Parliamentary Under-Secretary of State for Justice announced in a ministerial statement on 12 December 2007 that it was the government's intention to increase this level every three years to reflect inflation as measured in the Retail Price Index. Tettenborn (n 100) at 869.
[145] *Law Com*. 263 paragraph 6.3. *The Royal Commission on Civil Liability and Compensation for Personal Injury Cmnd 7054-1* (1978) at 96-98 paragraphs 418-431, would have preferred an even more inclusive list than that favoured by the Law Commission. These proposals were not implemented.
[146] Allen (n 78) at 271.

Looking abroad at other jurisdictions, one finds that while a 'parsimonious approach' in respect of the range of claimants has been adopted in England,[147] the list of 'immediate family' in Scotland is far more generous.[148] French law, most generous in its definition of dependants liable to obtain compensation for the death of a third person, makes awards which are similar to the amounts in English law and are seen as awards for *dommage morale,* retributory damages.[149] In Australia, *Lord Campbell's Act*[150] has been read down to allow recovery for loss only of economic or material advantages to the survivors. Damages in the nature of *solatium* for grief or bereavement (unless amounting to psychiatric illness), for loss of consortium or allowance for the gravity of the injury preceding death are rigorously excluded except where provided by statute. Not all jurisdictions have been content with the construction against recovery for all non-economic loss. However, legislative reform in South Australia[151] and the Northern Territory[152] has followed England[153] and has been cautious, limiting awards to spouses and parents of minors and usually setting a low monetary limit or fixed sum; the latter mode dispenses with any embarrassing inquiry into the bereavement.

In introducing the concept of damages for bereavement, statutory effect[154] was given to a recommendation of the Law Commission,[155] that 'an award of damages, albeit small, can have some slight consoling effect where parents lose an infant child or where a spouse loses a husband or wife'. The Commission considered that 'if money can, even minimally, compensate for such bereavement …it should be recoverable.'[156] Where an infant dies after attaining the age of 18, his parents will be unable to claim bereavement damages even if the injuries which led to his death were suffered before he was 18.[157] There is now provision for a fixed sum of £11,800 for bereavement damages which the

[147] Draft provisions of the Civil Law Reform Bill have sought to extend the list of relatives who may claim but the Bill has not materialised. G Dalyell, 'A Comparison of Fatal Accidents Claims in England and Scotland' (2011) *Journal of Personal Injury Law* 1, 10-18 at 12.
[148] Ibid at 11. Definition of 'immediate family' set out in s.1 (4) of the Damages (Scotland Act) 1976.
[149] Markesinis et al (n 3), 222.
[150] Now Fatal Accidents Act 1976, as amended by Administration of Justice Act 1982.
[151] Civil Liability Act 1936 (SA), ss 28-30.
[152] Compensation (Fatal Injuries Act (NT), s 10(f): without financial limits.
[153] Fatal Accidents Act 1976 (ENG), s 1A (bereavement). See Sappideen, and Vines (n 9), 759.
[154] S 1A of the 'Fatal Accidents Act 1976', as inserted by s 3(1) of the 'Administration of Justice Act 1982'.
[155] See 'Personal Injury Litigation-Assessment of Damages' *Law Com* No. 56 (1973) paragraphs 172-180. For the Law Commission's views on bereavement damages see 'Claims for Wrongful Death' (1997) Consultation Paper No. 148, paragraphs 6.1-6.65 (Part VI).
[156] Law Commission Consultation Paper No 148, paragraph 174. See discussion below 'money as redress with symbolic value'.
[157] *Doleman v Deakin* [1990] Times, 30 January, CA.

court cannot vary, and which is subject only to alteration by statutory instrument.[158] The 1982 Act is intended to ensure that, in the words of the Law Commission,[159] there will 'be no judicial enquiry at all into the consequences of bereavement'.[160] The fact that the new head of damage takes effect under the Fatal Accidents Act 1976, however, necessarily means that the award will only be recoverable if the deceased would have had a cause of action for negligence had he lived and also that the sum will, in fact, fall to be reduced if the deceased had been contributorily negligent.[161]

Finally, the Law Commission recommended[162] that the explanatory notes to their replacement clause on bereavement damages should clarify that the function of bereavement damages is to compensate, in so far as a standardised sum of money can, for grief and sorrow and the loss of the non-pecuniary benefits of the deceased's care, guidance and society. Such clarification is meant to be helpful, in particular as it would serve to preclude the idea that there is a punitive element to the award, or any reflection of the value of the life of the deceased. In that regard, as the Law Commission note,[163] 'no sum of money will be regarded as enough'.[164]

In conclusion, as has been seen, in wrongful death claims, two different types of actions may be brought, the 'survival action' and the 'dependency action'. After extensive consideration of claims for wrongful death, the Law Commission[165] essentially accepted the continuation of the two actions. It suggested extending the list of persons eligible to qualify for claims and made recommendations regarding levels of damages. It recommended that bereavement damages continue to be made available and clarified the function of bereavement damages as seen above. Although bereavement damages

[158] Ibid.
[159] Law Commission Report No. 56, paragraph 175. See McGregor (2003) (n 55), 540 para 26.44.
[160] Proof of mental distress is not required; an award of bereavement damages is not taken into account when assessing damages for psychiatric illness resulting from a death of another. Allen (n 78) at 271.
[161] Law Commission Report No. 56, paragraph 175.
[162] Law Reform (Miscellaneous Provisions) Act 1934, s 1 (1A).
[163] Law Commission 'Claims for Wrongful Death' (1977) Consultation Paper No 148.
[164] Interestingly, the Scottish Law Commission was mandated 'to consider the law relating to damages recoverable in respect of deaths caused by personal injury and damages recoverable by relatives of an injured person; and to make appropriate recommendations for reform.' This gave rise to the introduction of the Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill in the Scottish Parliament. The Bill seeks to allow sufferers of mesothelioma to settle claims for damages during their lifetime without, as would occur under the present law, automatically precluding a subsequent claim for non-patrimonial loss (grief, distress, sorrow and other intangible losses) by their immediate family.
[165] Law Commission 'Claims for Wrongful Death' (1999) *Law Com* No 263.

are statutorily fixed at £11,800,[166] and therefore are not a major cost in these types of actions, it is a moot question whether or not they achieve the redress function hoped for.

There are additional anomalies regarding damages payable for intangible losses. Damages for non-pecuniary loss may be awarded to victims of personal injury, but otherwise they will only be awarded for the death of a spouse or unmarried minor child under the Fatal Accidents Act. In other circumstances, no damages can be awarded for non-pecuniary loss. This rules out, for instance, any damages for the distress and anguish of parents whose child suffers crippling brain damage and whose life may thereby be shattered. Similarly, nothing is recoverable for the death of someone other than under the Fatal Accidents Act. So no damages will be awarded for the death of an adult child or of a non-marital partner; and a husband or wife cannot recover anything for the effects on themselves of a serious accident to their spouse. It was not suggested by Cane that there should be payment of damages for non-pecuniary loss in these situations, but the difficulty of justifying such damages in the cases where they are presently awarded was stressed.[167] For the reasons outlined above, primarily the symbolic value of these awards, I would continue the payment of damages for bereavement even though the loss is incommensurate with money.

IV. PECUNIARY LOSS ASPECT OF CLINICAL NEGLIGENCE CLAIMS

Viewed through the prism of the theory of corrective justice,[168] full compensation for the injury that the defendant caused to the claimant is required. A useful distinction can be drawn between what we might call 'equivalent compensation', on the one hand, and 'substitute/solace compensation', on the other. This distinction is based on the fact that the compensation provided by the tort system is in the form of monetary payments, but that not all of the adverse changes for which the tort law compensates are financial in nature. When tort law gives monetary compensation for adverse financial changes in a

[166] Currently, in 2011, the award for bereavement damages is £11,800. See P Balen, *Clinical Negligence* (Bristol, Jordan Publishing Limited, 2008) at 510 for discussion of the (DCA – Department of Constitutional Affairs) Consultation paper 'The Law on Damages' (2007) available online at: http://www.dca.gov.uk/consult/damages/cp0907.htm.

[167] Cane (n 24), 144, and ch 17 'The Functions of Compensation Systems'.

[168] See Chapman (n 33) for a full discussion of theoretical positions. Additionally, see Chapter 1 'Corrective Justice and Entitlement to Redress Within the NHS' above for a full discussion of the concepts of corrective and distributive justice. 'Corrective justice means to make required changes in an unjustified state of affairs between an injurer and a victim, when the injurer's activity has caused the injustice, so that changes bring about a just state of affairs between them, and one that is related in a morally appropriate way to the *status quo ante*.' Radin (n 35) at 60.

person's life, we can say that the compensation is equivalent to that which is compensated for; but this is not the case when those changes are not financial.[169] For present purposes, I have concentrated my discussion on the difficulties, theoretical and practical, of providing substitute/solace compensation. This is not to deny the enormous interest claimants have in receiving damages. Equivalent compensation does not present the same theoretical challenge as compensation for intangibles and I argue that despite the exigencies of the NHS, these should be paid to victims of iatrogenic harm along tort law principles. The detail of computation of pecuniary loss is beyond the remit of the thesis.[170] However, because the change in the method of payment of damages may have an impact on NHS finances, I will note the change in how damages are paid, lump sum or periodical payment, and consider the issue of claims for private medical expenses.

A. Lump Sum or Periodical Payment?[171]

Until 1 April 2005, the principle of full compensation was achieved by empowering the courts to award a lump sum, which once awarded was final. It could not be reopened and the claimant could spend it as he chose. This enabled finality and a sense of closure for both parties, but it was seen to be flawed, particularly in terms of the risk of over- or undercompensating due to the uncertainty of life expectancy.[172]

Parliament has reviewed the lump sum principle in two ways: first by providing for the possibility of provisional damages and latterly by providing for periodical payments in place of lump sums.[173] The courts now have the power to make a number of different types of personal injury award. They may (and in the majority of cases do) award a single once-and-for-all lump sum at trial. Alternatively, the judgment may be for a lump sum, but provisional, allowing the opportunity to one or other party to return to court in certain defined circumstances. In addition, since the early 1990s, in the case of larger awards, the courts have often made part of an award in an alternative form; namely, as a 'structured settlement', by which an annual payment is made indexed to provide protection against inflation. Until 2005, such awards were consensual only and could not be imposed on an unwilling claimant or defendant. Since 2005, the courts have been

[169] Cane (n 24), 412.
[170] See Tettenborn (n 100) and McGregor (2010) (n 31) for details of computation of damages.
[171] Brazier and Cave (n 133) at 233.
[172] Ibid at 234 and Balen (n 166) at 484.
[173] Tettenborn (n 100) at 711.

able to impose a periodical payments order (PPO).[174] This system of payment addresses some of the uncertainties generated by having to assess compensation as a lump sum because payment stops when the claimant dies. Periodical payments, paid for through self-financing, may therefore save the NHS some money and be fairer and more efficient.[175] There is, however, a mandatory requirement for the court to be satisfied as to the continuity of the future periodical payments by the defendant.[176] Where the source of the payment is a Government Health Service body,[177] problems have arisen because an NHS Trust is not technically such a body[178] and, in particular, because Foundation Trust Hospitals have financial autonomy and therefore can, in theory, be put into liquidation. These problems have now been resolved by the decision in *YM v Gloucester Hospitals NHS Foundation Trust and the Secretary of State for Health*[179] on the basis of agreements made between the NHS Litigation Authority and the Secretary of State for Health.[180]

B. Potential Problems in the Calculation of Pecuniary Loss: Medical Costs[181]

The most important item of expenditure usually concerns hospital, medical and nursing expenses, past and future. These are recoverable if reasonably necessary and in England one can claim for private provision: 'the test is not whether other care or treatment is reasonable but whether the care and treatment chosen and claimed for is reasonable…the test is whether the claimant has made a reasonable choice'.[182] However, in Australia and many other countries, the value of publicly funded medical and hospital services cannot be claimed because the victim will incur no expense. This is not the rule in the United States, however, where no comprehensive National Health

[174] See Damages Act 1996, ss 2-2B (as substituted by the (Courts Act 2003) and the Damages (Variation of Periodical Payments) Order 2005, SI 2005/841. See Brazier and Cave (n 133) at 236 for discussion and detail of PPOs.
[175] Ibid.
[176] Section 2 of the Damages Act 1996 and Part 41 of the Civil Procedure Rules.
[177] Defined in Damages (Government and Health Service Bodies) order 2005, SI 2005/474. Ibid at 722.
[178] Contrary to the decision of Sir Michael Turner in *Begum v Barnett and Chase Farm Hospital Trust* [2005] EWHC 3383 (QB).
[179] *YM v Gloucester Hospitals NHS Foundation Trust and the Secretary of State for Health* [2006] EWHC 820, [2006] PIQR P27.
[180] Tettenborn (n 100) at 722.
[181] Brazier and Cave (n 133) at 233.
[182] *Peters v East Midlands SHA* [2009] 3 WLR 737 at para 80. See Aldous (n 16), 227. If the claimant is reasonable in electing private funding over state funding then he is free to do so and need not give credit for future publicly funded provision. See Chapter 2 'What Patients Seek from Redress' above at 5. Patients seek continuing medical care.

Service exists.[183] A major problem of the tort system under which clinical negligence actions are pursued is that the system is inordinately expensive, with little more than half the insurance premium reaching the victim.[184] These high transaction costs are inherent in the system itself, the primary cause being the adversary relation between the claimant and the compensation source. Both liability and damages require investigation by expensive professionals and are frequently contested. The system is geared to individual processing and does not favour economies of scale.[185] Attempts at standardising compensation plans have not met with success.[186]

C. Conclusion: Pecuniary and Non-Pecuniary Loss

In England and Australia there has been fear that an increasing culture of blame has led to a compensation culture. However, research in both countries has not borne out the idea of ever increasing rates of litigation.[187] The rate of claiming has increased in the United Kingdom in the thirty years since the Pearson Report[188] largely because of an increase in knowledge that such claiming is possible; however, there is little or no evidence of a litigation 'explosion'.[189] There was an increase in litigation rates in the thirty years to the 1990s, but little increase *per capita* after that. However, the cost of claims, particularly the biggest damages awards for catastrophic injury, has increased dramatically, partly because of wage rises for nursing and similar professions and because of increased life expectancy.[190] I argue that victims of iatrogenic harm as a result of treatment in the NHS have an entitlement, based upon corrective justice principles, to compensation for their pecuniary loss. However, while not denying an entitlement to redress for their non-pecuniary loss, I would advocate searching for non-

[183] See Sappideen, and Vines (n 9), Chapter 10, at 268 for details of this and payments for care provided by family.
[184] Royal Commission (n 145). The Pearson Report at 83 estimated operating costs at 85% of the value of tort compensation payments. By comparison, the administrative cost of the New Zealand accident scheme is under 8%. See Sappideen, and Vines (n 8), 17. But the tort system fits the corrective justice model better.
[185] Ibid.
[186] Ibid at 18.
[187] See Sappideen, and Vines (n 9), 15, footnotes 63 and 64 for details of research articles.
[188] And the Harris Report '*Compensation and Support for Illness and Injury* (1984).
[189] R Lewis, A Morris and K Oliphant, 'Tort Personal Injury Claims Statistics: is there a Compensation Culture in the United Kingdom?' (2006) 14 *Torts Law Journal* 158.
[190] In 2010/11, 8,655 claims of clinical negligence and 4,346 claims of non-clinical negligence against NHS bodies were received by the NHSLA, up from 6,652 claims of clinical negligence and 4,074 claims of non-clinical negligence in 2009/10.£863 million was paid in connection with clinical negligence claims during 2010/11, up from £787 million in 2009/10. NHSLA website: http://www.nhsla.com/home.htm

pecuniary means of recompense. This is both because these losses are, by their nature, non-commodifiable and the nature of a welfare health system, based on distributive justice principles, means that the population's claims for treatment rather than redress must also be respected. I now turn to the complicated issue of redress for psychiatric harm.

The issue of redress for intangible, psychiatric rather than physical harm merits discussion because the restrictions placed on recovery for psychiatric harm in the Hillsborough accident cases[191] have left a legacy of concepts, language and analysis ill-suited to clinical negligence cases.[192] The courts have had difficulty with claims for 'pure psychiatric damage', where the claimant has not suffered any physical injury. Although most of the problematic cases have involved claims for psychiatric harm sustained by third parties as a result of witnessing traumatic events to others, some have involved claims by individuals arising out of events in which they were participants. In the medical context, this could include, for example, psychiatric damage resulting from medical treatment where the patient has not yet sustained any physical injury or upon the negligently conveyed communication of distressing news. In addition, there are secondary claims for psychiatric injury from close relatives arising from negligently harmed primary patients. The issues that such cases raise are so closely linked to the broader question of how the courts react to claims for psychiatric damage generally, that these cases are discussed along with those involving claims for psychiatric damage by third parties.[193] After the discussion, ideas of potential reform of this area of law will be canvassed.

[191] Alcock v Chief Constable of South Yorkshire Police [1992] 1 AC 310 (hereafter Alcock) White v Chief Constable of South Yorkshire Police [1999] 2 AC 455 (hereafter White) and Frost v Chief Constable of South Yorkshire [1997] 3 WLR 1194 (CA) (hereafter Frost). In the Hillsborough litigation the courts were anxious to avoid the risk of unlimited liability to an unlimited number of persons. H Teff, Causing Psychiatric and Emotional Harm: Reshaping the Boundaries of Legal Liability Hart Publishing (2009) chapter 1 and pages 83-97. Note: With the publication of The Report of the Hillsborough Independent Panel in September 2012 criticising the public services' response and responsibility for the disaster, the legal issues will be revisited.

[192] The classification of primary and secondary victim situations in determining to whom a duty of care is owed. P Hanford, 'Psychiatric Injury: In Breach of a Relationship' (March 2007) 27 *Legal Studies* 1, 26-50.

[193] Ibid at 178.

V. PSYCHIATRIC HARM IN THE CLINICAL NEGLIGENCE SPHERE

One area where I argue that the present law is unsatisfactory is in its dealing with claims for psychiatric injury not attendant upon physical injury. Discussion of psychiatric harm is conventionally to be found under problems of duty of care, as the focus of litigation has been in setting boundaries limiting the class of potential claimants.[194] In the context of this chapter on damages, claims for psychiatric harm offer examples of both pecuniary and non-pecuniary loss. In the following analysis, I will discuss the problem of the medical and legal classification of psychiatric harm,[195] the issue of liability for psychiatric harm and note proposals for reform.[196] In conclusion, for comparison, I consider recent court decisions and legislative initiatives in Australia.[197]

A. Mental and Emotional Harm: Problems of Classification

Initially, there are difficulties with the definition and classification of what counts as harm for the purposes of legal redress. The medical and legal definitions are not co-terminous. The courts have been consistently uneasy about compensating claimants for pure psychiatric harm because of a widespread mistrust of intangible harm. The most high profile cases in recent times have concerned the Hillsborough football stadium disaster. A common thread running through the House of Lords decisions[198] is the spectre of proliferating claims and 'virtually limitless liability' should the controls be abandoned. It will be argued that the concerns about proliferating claims and the perceived difficulty in diagnosing psychiatric illness have been overstated. Meanwhile, manifestly deserving claimants are thwarted by rules that have long been a blot on the legal system, perpetuating a mismatch of law and medicine. After a discussion of these

[194] In the Hillsborough litigation the courts were anxious to avoid the risk of unlimited liability to an unlimited number of persons. Teff (n 191). See also above. Chapter 4 'Proving Clinical Negligence' where I have discussed the question of to whom a duty of care is owed.
[195] A distinction is made between 'psychiatric harm' (passes the threshold of an illness) and 'mere grief and sorrow' which is not compensable. The insistence on this distinction does not exist in the United States. While this distinction helps to keep the floodgates closed, the fact that the distinction does not really exist in psychiatry makes it problematic. P Vines, M San Roque and E Rumble, 'Is "Nervous Shock" Still a Feminist Issue? The Duty of Care and Psychiatric Injury in Australia' (2010) 18 *Tort Law Review* 9.
[196] Teff (n 191), Chapter 6 at 171.
[197] Ibid.
[198] *Alcock* 417, per Lord Oliver and *White* 494, per Lord Steyn.

House of Lords decisions, I will focus on the issue of claims for psychiatric harm in the medical, rather than accident scenario, ending with thoughts about the way forward.[199]

The history of ethereal torts displays a consistent and repeated pattern: the devaluation, diminishment and dismissal of injuries to the psyche despite evidence that it is precisely those sorts of injuries that harm people profoundly – injuries that matter the most:

> The initial division of deserving and undeserving plaintiffs is the separation of those suffering physical injuries from those suffering mental injuries. Those incurring physical harms are readily compensated. Those incurring psychic harms face scepticism, heightened burdens of proof and a history of precedents that treat the interest in emotional equilibrium as unworthy. In infliction of emotional distress cases, the injuries complained of are often presumptively treated as pre-existing flaws in the individual's psychological make-up.[200]

It is widely accepted that the current state of the law governing psychiatric injury is unsatisfactory. The traditional approach to the duty of care in 'nervous shock cases' requires more hurdles to be met than in cases of ordinary physical injury. The rules are generally considered to be overly complex, inconsistent and lead to the drawing of arbitrary distinctions. This dissatisfaction is shared by members of the senior judiciary.[201] The medical and legal systems address the issue of mental and emotional harm from understandably different perspectives. I am including a detailed discussion of the tensions between the legal and medical understanding of the terms because they are beneath the surface in almost all aspects of the thesis, from causation to redress. The problem for present purposes is that modern law regarding psychiatric injury is predominantly carved from litigation concerning accidents, in particular, the Hillsborough litigation.[202] The most important requirements apposite to accident scenarios include the presence of a 'recognisable psychiatric illness', usually Post-Traumatic Stress Disorder,[203] caused by a particular traumatic event. The courts have restricted liability to claimants who are considered proximate to the accident scene. As

[199] For much of my analysis in this field I am indebted to Teff (n 191).
[200] N Levit, 'Ethereal Torts' (1992) 61 *George Washington Law Review* 136.
[201] D Nolan, 'Psychiatric Injury at the Crossroads' (2004) Journal *of Personal Injury Law* 1-20 page 16.
[202] *Alcock* and *White*. On 15 April 2009, twenty years after the disaster, relatives of the victims and the general public remain convinced that justice has not been done. Relatives of the Hillsborough disaster victims have demanded 'full' disclosure from secret files about the tragedy after the Home Secretary promised families help from the Government. Cabinet papers regarding Hillsborough are to be released. The Guardian 25 August 2011.
[203] Hereafter PTSD.

will be addressed, these concepts of sudden shock and 'primary' and 'secondary' victims, when superimposed on clinical negligence cases, are a poor fit.[204]

B. Medical Classification

Although 'personal harm', as generally understood, extends well beyond bodily injury, no single term fully captures the sheer range of suffering which is not manifestly physical. The field of inquiry regarding legal redress for 'mental and emotional harm' immediately raises formidable and unresolved difficulties of appropriate terminology. When viewed from the medical perspective, emotional reactions to traumatic stimuli are often more nuanced than the effects of physical injury. To an extent not always open to the law, medicine can allow for levels of uncertainty and gradation when categorising a patient's mental condition. A basic distinction can, nevertheless, be drawn between 'primary' and 'secondary' reactions to trauma. Primary reactions are immediate, automatic and instinctive. They are transient, subjective sensations such as fear, anger or shock which have various physiological repercussions that affect the nervous system. Though very common, such symptoms are normally offset by a defence mechanism which allows the sufferer to cope. In a small minority of cases, however, longer-lasting secondary reactions develop, often in the form of traumatic neuroses. A person's emotional make-up is a key predictor of such consequences, but there will be other variables, such as the intensity of the stimulus, the degree of preparedness for it and, crucially when injury to another is the trigger, the intensity of the relationship between the individuals concerned.[205]

The main neurotic reactions to trauma are now commonly divided into PTSD and certain other conditions, such as depressive illnesses, adjustment disorders and anxiety disorders.[206] All of these conditions can be induced by shock, but PTSD is distinctive in that the diagnosis depends on exposure to an external and severely traumatic event outside the range of normal human experience. PTSD is also characterised by re-experiencing' the traumatising event and by the emergence of persistent 'avoidance' and 'arousal symptoms'. It is widely acknowledged within psychiatry that the boundaries of mental disorder are not exact. Although there is no definitive

[204] Primary victims are treated more favourably than secondary victims. See below.
[205] Teff (n 191), 6.
[206] Gelder et al, Ibid at 137 ff; Law Commission No 249, *Liability for Psychiatric Illness* (London, HMSO, 1998), s B: The Medical Background, 38-54.

classificatory system of mental disorders, the most widely accepted works of this kind are those of the American Psychiatric Association (DSM-IV) and the World Health Organisation (ICD-10). As works of reference which set out diagnostic criteria, these manuals constitute a valuable resource for the psychiatric profession. In the context of litigation, their criteria also routinely feature in the written opinions and evidence of expert witnesses.[207]

It is clear, however, that DSM-IV and ICD-10 are not designed to satisfy legal criteria for remediable harm. There is no universal agreement within psychiatry on what constitutes a 'recognisable psychiatric illness', nor, if there were, is it obvious that it should be the legal recovery threshold for negligently inflicted 'pure' mental harm. There is no reason why one should expect the particular classificatory system in a medical treatise to be totally congruent with the requirements of a liability regime that are inevitably shaped by the development of legal doctrine, as influenced by notions of culpability and various social and economic considerations. In the court setting, then, DSM-IV and ICD-10 serve as valuable guidance to be considered in the light of other relevant factors, which include clinical judgement. Such works cannot be dispositive of legal decisions, and some medical experts maintain that their categories 'do not reflect the complexities of the psychological impact of trauma', given that conditions not 'officially' classified may prove more disabling, depending on the particular facts.[208] Nonetheless, the influence of these diagnostic systems in the legal context is undeniable, as is apparent from how soon PTSD became a prominent basis of claims once it had been accepted as a distinct diagnostic category. What remains unfortunate is the extent to which certain legal criteria of liability fly in the face of generally accepted scientific understanding.

C. Legal Classification

If medical opinions differ on how to define and label particular mental conditions, so too the law is far from uniform in classifying and providing remedies for mental and

[207] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* Washington DC, American Psychiatric Association, 4th edn TR (2000), generally referred to as DSM IV and World Health Organisation, *International Classification of Diseases and Related Health Problems* Geneva, World Health Organisation, 10th revision vol 1 (1993), generally referred to as ICD 10.
[208] See Scottish Law Commission, *Discussion Paper on Damages for Psychiatric Injury* (Edinburgh, The Stationery Office, 2002) No 120, paragraph 2.8.

emotional harm. The chequered history of the term 'nervous shock' is a case in point.[209] The question, for our purposes, is to what extent can a doctor, who negligently treats a patient, be liable for psychiatric injury to the patient or his relatives where that psychiatric injury is the only injury suffered by the patient or relative?[210] The answer, as previously noted, is to be found in four House of Lords decisions.[211]

The distinction between primary and secondary victims is important. Where the patient has been exposed to a risk or danger, the patient is entitled to claim for pure psychiatric injury as a primary victim. A relative would be classified as a secondary victim whose ability to recover compensation is subject to the test laid out by the House of Lords, namely, that the claimant has to prove that: (1) there was a recognised psychiatric injury and not merely grief, (2) this resulted from shock, ie the sudden and direct appreciation by sight or sound of a horrifying event or events, (3) there was propinquity in time or space from the causative event or its immediate aftermath, (4) the injury was reasonably foreseeable and (5) that the relationship between the claimant and defendant was sufficiently proximate.

In the leading clinical negligence case of *Sion v Hampstead HA*[212] P Gibson LJ made clear that a claim of this sort would not fail simply on the basis that there is no 'unexpected' or 'shocking' event. What is crucial is the unexpected or shocking nature of the discovery by the claimant. There remains, however, the distinction between a gradual onset of psychiatric harm and a psychiatric injury which flows from a sudden 'shock.' A more flexible approach to this criterion is illustrated by the case of *Walters v North Glamorgan NHS Trust,*[213] where a baby was negligently misdiagnosed leading to his death from acute hepatitis and his mother recovered compensation for the psychiatric harm she suffered in circumstances where the baby died 36 hours after the mother's initial appreciation that her son was seriously ill. Thomas J held that the period

[209] Teff (n 191), 7.
[210] P Balen (n 166) at 175.
[211] *McLoughlin v O'Brien* [1983] 1 AC 410; *Alcock v Chief Constable of South Yorkshire Police*: [1992] 1 AC 310; *Page v Smith* [1996] AC 155*; White v Chief Constable of South Yorkshire Police* [1999] 1All ER1.
[212] *Sion v Hampstead HA* [1994] 5 Med LR 170 (CA). This case concerned a father's claim for psychiatric illness, following an 18 hour-a-day vigil for 14 days, which included a series of traumatising events. It was struck out because there was 'no trace in the medical report of 'shock' as defined by Lord Ackner. Rather, it was 'a process continuing for some time, from first arrival at the hospital to the appreciation of medical negligence after the inquest' per Straughton LJ at 174. For extensive case law see Teff (n 191), 117 and M Jones, *Medical Negligence* Sweet & Maxwell 4th edn (2008) 178-223.
[213] *Walters v North Glamorgan NHS Trust* [2002] Lloyd's Rep Med 227.

of 36 hours from when the mother first saw her son having an epileptic fit through to the time of the baby's death was a horrifying event. The initial witnessing of the fit was not such an event in its own right, but the court should look realistically at all the events which happened over the period until death. Also, the psychiatric evidence meant that it was not possible to isolate the causative effect of each incident within the 36-hour period. The accumulation of all events had contributed to the injury.

The Court of Appeal affirmed the ruling, stating that the court should take a realistic view of the word 'event' and should not be overly restrictive in its interpretation, so that a series of events may satisfy the test, depending upon the individual circumstances of the case.[214]

D. Liability for Psychiatric Harm: 'Beyond the Mainstream' – The Current Position

The liability rules for negligently caused mental harm were essentially crafted with accident-based claims in mind. Whether one thinks of the rail or road crashes which shaped the early law or mass disasters at particular venues, the paradigm is an untoward physical event causing shock-induced psychiatric illness.[215] Throughout the twentieth century, presence in the 'zone of danger' and instant fright were stock features of the case. The primary/secondary divide is but the latest construct to confirm the law's preoccupation with physical proximity to a particular physical incident.

Yet there are numerous types of situation in which the accident-driven rule structure has little or no meaningful purchase. Often the negligent conduct complained of is not 'accident-based' as described above, so that there is no-one who fits the narrow *Page/White* formula for primary victims, or who could satisfy the range of legal criteria for secondary victims.[216] When negligent delivery of services or of bad news causes psychiatric harm, there is no 'accident scene' and only in exceptional circumstances would the recipient have been physically endangered. This is also so when the harm results from a prolonged hospital vigil for negligently treated dying family members.[217]

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[214] Balen (n 166) at 176.
[215] Teff (n 191), Chapter 1, 2-3.
[216] For example, *Farrell v Avon Health Authority* [2001] Lloyd's Rep Med 458, and *Walters* (n 213).
[217] *Sion v Hampstead HA* (n 212).

In many contexts, to insist that the claimant fit within the accident-driven format either rules out liability arbitrarily or prompts yet more artificial analysis.

In the fraught environment of the hospital, the natural anxieties of patients and people intimately connected with them are often heightened by inadequate information or mixed messages. The traumatic experience of a long drawn-out vigil, with intermittent crises and hopes raised only to be dashed, or an extended process of dawning realisation culminating in the trauma of attendance at the mortuary, can provide ample evidence of 'causal proximity'.[218] Yet under *Alcock,* whatever the surrounding circumstances, secondary claims would appear to require a specific traumatic incident. A review of the recent case law shows a mixed picture of a declining insistence on 'sudden shock' and a lingering potential for restrictive analysis in the hospital setting.[219]

The 'shock, horror' model of how psychiatric harm is induced, with its enduring hold on the popular imagination, has long been mirrored in the legal setting.[220] If deprecated of late in the case law, it still has undue capacity to determine legal outcomes.[221] The inclination towards more liberal interpretation in the hospital cases seems, in part, attributable to judicial empathy, a tacit recognition of the narrowness and rigidity of the liability rules. It also reflects the fact that, in this setting, the case for restricting 'secondary' claims for want of 'sufficient proximity' looks distinctly thin. There is commonly a nexus between the hospital and those closest to the patient, whose 'presence', when not actually known about as a fact, is readily foreseeable, even if they seldom perceive a shocking event. Abandonment of the shock requirement would be both an important symbolic and practical demonstration of the progressive understanding of psychiatric harm which the House of Lords has asserted in recent years. These hospital cases are clearly distinguishable from the accident cases because of the prior link between the claimant and the defendant and this link has been invoked to justify strained interpretations of the doctrinal barriers to recovery. Some judges have been emboldened either to disregard a particular restrictive device or to dispense with all the special controls in favour of broader negligence criteria.[222] An argument put forward by Harvey Teff for broadening the scope of mental harm to include instances

[218] *Jaensch v Coffey,* [1984] 155 CLR 549 at 606-607, per Deane J.
[219] For extensive case law see Teff (n 191), 117 and Jones (n 212).
[220] D Mendelson, *The Interfaces of Medicine and Law* (Aldershot, Dartmouth Publishing Co., 1998).
[221] *Tan v East London and City Health Authority* [1999] Lloyd's Rep Med 389.
[222] Teff (n 191), 98.

which fall short of a 'recognisable psychiatric illness' is supported by judgments in the Australian courts.

E. The View from Afar: Australia
Tame v New South Wales; Annetts v Australian Stations Pty Ltd[223]

In these two cases[224] the court largely repudiated the use of limiting devices as preconditions of liability in favour of a more principled and rational approach grounded in reasonable foreseeability.[225] Direct perception, sudden shock and reasonably foreseeable harm in a person of 'normal fortitude' were all downgraded to mere features helping to establish foreseeability.[226] This decisive departure from prevailing English law on psychiatric harm was sadly short-lived. There was a sea change in the law and the fruits of *Tame* and *Annetts* were swiftly abandoned in hastily drawn up legislation. At the turn of the century, Australia saw a dramatic rise in the cost of personal liability insurance and corresponding reductions in risk coverage. What was perceived as an 'insurance crisis',[227] symbolised by the collapse of a major general insurer, HIH, generated political and media-driven debate about litigation rates, the breadth of negligence liability and the level of awards, concerns endorsed by some members of the judiciary.[228] Tort law reform was already on the agenda in several States when, in 2002, the Federal Government instituted a major review of negligence law, chaired by Justice

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[223]*Tame v New South Wales; Annetts v Australian Stations Pty Ltd* [2002] 211 CLR 317. 'The Australian High Court thus leads the common law world in recognising that psychiatric injuries are as real as physical injuries and that the rights to recover should depend on whether such injuries are reasonably foreseeable, freed from artificial and outdated policy restrictions imposed because of a perceived need for additional limits'. P Handford, *Mullany and Handford's Tort Liability for Psychiatric Damage* 2nd edn (Sydney, Lawbook Co., 2006) 1,180.

[224]In *Tame* (n 223), Mrs. Tame, who was in a car accident, developed an obsession about an erroneous police report that suggested she had been drinking. Although the mistake had been rectified, she continued to suffer from a psychotic depression. On the facts, it was held that it could not be said to be foreseeable that Mrs Tame would suffer psychiatric injury as a result of learning about the error on the accident form. In *Annetts* (n 223), the High Court heard a case where the parents of a sixteen year old jackaroo working on a sheep station in the remote north of Western Australia were informed of his disappearance, and four months later of his death. It was held that the parents were owed a duty of care despite not having been at the accident scene. The High Court removed the requirement of direct perception. Sappideen, and Vines (n 9), 183.

[225]Teff (n 191), 131.

[226] Ibid at 131-132 in *Annetts*, (n 223) the judges relied on the pre-existing relationship between the parents and the employers; *Tame* (n 223) failed on the facts of the case. See also Vines, San Roque and Rumble (n 195).

[227] However a report on trends in Australian personal injury litigation E Wright, *National Trends in Personal Injury Litigation: Before and After 'Ipp'* (Canberra Australia, 2006) found that contrary to widespread belief, litigation rates had not, generally, been increasing in the period leading up to the Ipp Review (n 229); nor were data available to confirm that personal injury claims were becoming more successful or producing increasingly large awards. There was no evidence that personal injury litigation was the 'root cause of the insurance crisis'. Teff (n 191), 137.

[228] Ibid at 135 footnote 231 therein.

David Ipp.[229] As a direct consequence of the Ipp Report's recommendations, substantial wide-ranging reforms were implemented, mainly between 2002 and 2004, in all Australian jurisdictions.[230] *Tame* and *Annetts* were immediately partially overturned by legislative amendment in New South Wales. There, and in several other States, a test based on a claimant of 'normal fortitude' has been designated a *precondition* of foreseeability of psychiatric harm in psychiatric injury cases[231] and some new statutory provisions are more restrictive than those recommended in the Ipp Report. In particular, as regards secondary victims, several States have confined recovery to claimants who are either present or at the *scene* of an accident and see another person being killed, injured, or imperilled[232] or who are in a 'close relationship' with such a person.[233]

In conclusion, I would agree with Teff and Vines that the present restrictive English law regarding liability for psychiatric harm absent physical injury needs revision. However, while I would be the first to acknowledge the reality of the pain and suffering inherent in psychiatric harm, I nonetheless would eschew damages for the non-pecuniary loss aspect of psychiatric harm occasioned in the NHS sphere for the reasons rehearsed above. I now turn to the legislative reforms in Australia, looking more broadly at personal injury claims.

VI. THE AUSTRALIAN EXPERIENCE: PECUNIARY AND NON-PECUNIARY LOSS

England is not alone in struggling to find affordable means of redress for personal injury. The Australian reforms of 2002–2004 were enacted against a 'catchcry' or slogan of personal responsibility[234] and the notion of a compensation culture which galvanised governments into passing legislation constraining the common law of

[229] Department of the Treasury, *Review of the Law of Negligence: Final Report* (Canberra Department of the Treasury, 2002) (The *Ipp Report)*.
[230] See L Skene and H Luntz, 'Effects of Tort Law Reform on Medical Liability' (2005) 79 *Australian Law Journal* 345.
[231] Civil Liability Amendment (Personal Responsibility) Act 2002 (NSW) s 32.
[232] This seems to exclude aftermath cases.
[233] Civil Liability Act 2002 (NSW) s 30. See Teff (n 191), 136-137 for more detail on psychiatric harm. Also Chapters 5 and 6 for proposals for reform in this area of law namely; unqualified threshold; threshold based on severity of harm caused; threshold requirement for award of damages for non-pecuniary loss in all personal injury claims based on the duration of the harm caused; and implementation of financial threshold for emotional distress based on *Judicial Studies Board* (n 74).
[234] Amendments to the Act in New South Wales was called the Civil Liability (Personal Responsibility) Amendment Act 2002. See Sappideen, and Vines (n 9), 15.

torts.[235] An important catalyst for these changes was the medical profession. The increases in medical indemnity insurance in Australia made the doctors a potent lobby in the tort reform process. Similar problems arose in the NHS which gave rise to the NHS Redress Act 2006.[236] In the United States, a perceived crisis in medical indemnity insurance occurred in the 1970s and led to some tort reforms. This was followed by further crises in the 1980s and in the late 1990s.[237] The anxiety of medical practitioners went unassuaged and legislatures responded not only to constrain the law of torts but also to reduce litigation by other means such as taking certain medical adverse events out of the litigation process[238] and protection of apologies in civil liability, especially in relation to medical malpractice.[239] As regards non-pecuniary loss, there are limiting thresholds in several jurisdictions.[240] In Queensland, there are caps on damages, restrictions on compensation to family and friends for free care and limits on legal fees refundable for smaller claims.[241] In Victoria, there are restrictions on medical negligence claims, particularly the requirement that medical experts must determine that a patient has suffered impairment of at least 6 per cent due to a physical injury and at least 11 per cent in the case of psychiatric problems before a claimant can sue.[242]

One possible response to the restrictive legislative scheme[243] would be for judges to enhance justice by highlighting the hardships and iniquities this legislation creates for injured claimants. However, while Thomas Faunce[244] hopes for and anticipates a no-fault compensation system in Australia, Prue Vines[245] notes that in the last decades, social welfarism has lost its earlier appeal due to financial stringency. Public policy has

[235] Ibid Sappideen at 15 footnote 64 therein '…this includes capping damages, creating thresholds for liability, changing tests for liability, increasing power of defences, and using various other devices for reducing both the incidence and cost of litigation.' See also Civil Law Wrongs Act 2002 (ACT); Civil Liability Act 2002 (NSW); Civil Liability Act 2002 (WA); Civil Liability Act 2002 (Tas); Civil Liability Act 2003 (Qld); Personal Injuries (Liabilities and Damages) Act 2003 (NT); and by amendments to the Wrongs Act 1958 (Vic) and the Wrongs Act 1936 (SA). Trade Practices Amendment (Personal Injury and Death) Act (No. 2) 2004 (Cth).
[236] Discussed in Chapter 8 'The NHS Redress Act 2006 – A Lost Opportunity?' below.
[237] See Sappideen, and Vines (n 9), 16 footnotes 65 and 66.
[238] NHS Redress Act 2006 which applies to matters worth less than £30,000.
[239]This has occurred in Australia, the United States, Canada and the United Kingdom: P Vines, 'Apologies and Civil Liability in the UK: a View from Elsewhere' (2008) 12 *Edinburgh Law Review* 200. Also see Sappideen, and Vines (n 9), 276-284 for details of legislation in Australia, Canada the UK and the USA. See also Chapter 9 'Effective Redress' below.
[240] Sappideen, and Vines (n 9), 278.
[241] TA Faunce, 'Reducing Injustice From Recent Legislation Subsidising Insurance and Restricting Civil Liability' (2010) 15 *Journal of Law and Medicine* 5, 729 at 730.
[242] Ibid at 731 for more examples of statutory restrictions.
[243] Ibid.
[244] Ibid at 735.
[245] Sappideen, and Vines (n 9), 18.

veered from expanding to reducing public expenditure for social welfare and 'privatising' formerly governmental responsibilities. Notions of individual responsibility and private choice are gaining at the expense of social welfare. She anticipates that this will be reflected increasingly in a preference for voluntary first-party insurance over no-fault compensation, and even over tort liability with its satellite of third-party insurance.[246]

The landscape in England appears much as Vines describes it[247] and it is clear that the no-fault option has been eschewed by the British Government.[248] It has been instructive to consider how other jurisdictions grapple with issues arising from iatrogenic harm.[249] Whereas in England the question of whether or not compensation should be paid for the maintenance of a healthy child who was born as a result of negligent advice following a sterilisation operation was decided in the negative by the House of Lords,[250] in Australia, after *Cataract*,[251] recovery is allowed. One reason for this is that Australia did not follow the principle of *Caper* as to whether it was fair, just and reasonable to impose liability and instead held that 'to deny such recovery is to provide a zone of legal immunity to medical practitioners…that is unprincipled and inconsistent with established legal doctrine'.[252] Kirby J suggested that to deny recovery would be an arbitrary departure from the principle of corrective justice.[253] However, in a concession to the House of Lords, Justice Kirby acknowledged that concern to protect the economic viability of the NHS might help to explain its resort to 'distributive justice; such concerns could, however, find no place in Australian public policy.'[254]

The present overwhelming worldwide financial challenges for governments has resulted in retrenchment of welfare payments, and theoretical models currently take second place to strictly financial burdens. Nonetheless, I continue to argue that victims of iatrogenic

[246] PS Atiyah, 'Personal Injuries in the Twenty-First Century: Thinking the Unthinkable', in P Birks (ed) *Wrongs and Remedies in the Twenty-First Century* (Oxford, Clarendon Press, 1996).
[247] See Chapter 3 'Funding Litigation' above. Also Part III 'Redress within the NHS' below.
[248] 'Making Amends: A Consultation Paper setting out Proposals for Reforming the Approach to Clinical Negligence in the NHS: A report by the Chief Medical Officer' (June 2003).
[249] JK Mason, 'A Turn-Up Down Under: *McFarlane* in the Light of *Cattanach*' (2004) *Scripted* Volume 1, Issue 1. The High Court rejected the House of Lords decision in *McFarlane*.
[250] *McFarlane v Tayside Health Board* [2000] 2AC 59. See Chapter 1 'Corrective Justice and Entitlement to Redress within the NHS' above for discussion of *McFarlane* and distributive justice arguments against recovery for the maintenance of a healthy child after negligent advice.
[251] *Melchior v Cattanach* [2000] SC1 (HL); [2000] AC 59.
[252] Ibid at para 149. Mason (n 249).
[253] *Melchior* (n 251) at para 180.
[254] Mason (n 249).

harm occasioned within the NHS should receive their financial redress for pecuniary loss and I will consider alternative redress for non-pecuniary loss in my closing chapter.[255]

VII. CONCLUSION: DAMAGES AS REDRESS FOR IATROGENIC HARM: PECUNIARY AND NON-PECUNIARY LOSS

> Damages for pain, suffering and loss of amenity is a secondary form of compensation, incapable of precise assessment and less able than pecuniary damages to provide an equivalent to what has been lost. A 'correction' cannot be made. It is compensation deserving a lower priority than that awarded for financial loss.[256]

It is important to note that for a claimant who chooses the legal route to redress, the remedy in a clinical negligence action is damages and that the claimant's wish for 'a guarantee that this will never happen to anyone else' (or similar forms of redress) is not achievable within a court's judgment.[257]

I shall make a brief remark regarding compensation for pecuniary loss due to negligence in the NHS sphere. Although in practical terms, the calculations for pecuniary loss give rise to actuarial complexities, in philosophical terms, monetary damages are seen as satisfying the equivalence test by replacing like with like and are therefore unproblematic. While admittedly, the emphasis in this chapter on damages has been more focused on the philosophy, practicalities of quantification and methods of payment regarding damages for non-pecuniary loss, I have also discussed damages in respect of death and bereavement; calculations and payment for pecuniary loss; redress for psychiatric harm, and have noted how these issues are tackled in other jurisdictions, most notably Australia. The fact that there are concerns regarding the unequal distribution of compensation, payments between those people who qualify because of tort and those who have not been negligently damaged but are ill or disabled, is outside the remit of this thesis.[258]

I have argued that, from a corrective justice vantage point, victims of iatrogenic harm occasioned within the NHS have an entitlement to full redress for both pecuniary and

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[255] Chapter 9 'Effective Redress' below.
[256] Cane (n 24).
[257] For these remedies see Part III 'Redress within the NHS' below.
[258] Ibid Introduction. Also J Stapleton, 'Compensating Victims of Disease' (1985) 5 *Oxford Journal of Legal Studies* 248.

non-pecuniary loss. However, this entitlement is constrained by the competing responsibility a universal healthcare service has to deliver treatment to society at large.

There is a tension between funding redress and funding treatment. I argue that the pecuniary losses should be reimbursed because the NHS should be held to the requisite standard of a competent health service. However, because non-pecuniary loss is incommensurate with money, more appropriate redress might be found.[259] I am limiting this argument to the specific instance of a universal health service under the assumption that money not spent on damages would go directly to patient care. As regards redress for wrongful death, I have argued in favour of retaining the bereavement payment. Although this is inconsistent with my overall stance regarding non-pecuniary loss, I would keep this payment because it is an expected, conventional sum with symbolic meaning and its removal would cause unacceptable hurt.

Turning to the question of liability for psychiatric harm, particularly in the absence of physical harm, I have discussed the unsatisfactory state of the law at present. In clinical negligence cases, the victims may well be relatives as well as patients and would fall foul of the artificial constructs for primary and secondary victims. I have noted the extra burdens placed on claimants for psychiatric harm. I would argue that diagnosis is not as problematic as the courts infer; the percentage of the population who might succumb to PTSD is not more than 1 in 3,[260] and the floodgates argument is invalid. That said, the question of compensation for pure psychiatric harm remains challenging in England and Commonwealth jurisdictions. I argue that psychiatric harm should be treated on an equal footing with physical harm and therefore damages are due for pecuniary loss and bereavement payment but not for the non-pecuniary loss.

In the closing section of the chapter, I have looked at judicial and legislative initiatives around this aspect of tort law in Australia. After some enlightened judicial decisions in the area of psychiatric harm, legislative responses to a perceived but inaccurate notion of a compensation culture restricted liability and redress for injured patients. While there is some scope for judicial interpretation to counterbalance the legislation, the

[259] See Part III 'Redress within the NHS' below.
[260] Royal College of Psychiatrists Website. Post-traumatic Stress Disorder: key facts http://www.rcpsych.ac.uk/mentalhealthinfo/problems/ptsd/ptsdkeyfacts.aspx

present financial crisis finds governments retrenching on all aspects of welfare rights, from treatment itself to withdrawal of legal aid and limits on redress.

This chapter concludes Part II Medical Negligence Litigation and I now turn to Part III Redress within the NHS.

PART III

REDRESS WITHIN THE NHS

CHAPTER 7

HISTORY OF THE NHS COMPLAINTS PROCESSES
'A CURATE'S EGG'?

In a perfect world, no doubt things would never go wrong in hospitals: no one would ever complain or have cause to do so…This is a trite observation, but it leads to the point which we want to make. This is absurd and leads to dissatisfaction, inefficiency or worse – to pretend or persuade oneself that things never do go wrong.[1]

The best place for a lawyer in the NHS is on the operating table.[2]

[1] Sir Michael Davies, Chairman *Report of the Committee on Hospital Complaints Procedure,* Her Majesty's Stationery Office (1973) page 4.
[2] Frank Dobson, Health Secretary, Department of Health Press Release, 29 April 1998.

I. INTRODUCTION

This thesis focuses on redress for iatrogenic harm incurred through clinical negligence in the English NHS. In a sense this is where both philosophical and practical issues are at their most acute. The tortfeasor's intent, leaving to one side instances of gross negligence and aberrant behaviour, is to provide a positive good. The human cost of a doctor's error can be great, and monetary compensation is inadequate when the mistake results in disability or death of the patient.[3] The money used to pay compensation comes out of a limited budget in which there are competing claims for healthcare.

The preceding section of this thesis[4] was concerned with claimants obtaining financial recompense through litigation. This section concerns redress within the NHS and focuses on non-litigious and non-financial remedies for alleged clinical negligence, in particular, the increasingly important NHS complaints procedures. Where financial compensation is barred by virtue of limitations on legal aid and civil law reform,[5] more pressure will be placed upon the complaints system and professional regulation to deliver appropriate sanctions, communication and correction.[6] I argue that a complaints system that functions well would offer a significant alternative route of access to justice for iatrogenically harmed patients.

According to the Health Ombudsman,[7] complaints can be complex, covering extended periods of time and multiple issues of maladministration or service failure. Clinical care and treatment form the largest subject category, followed by the attitude of the NHS staff. The type of harm being discussed is often the result of poor communication and insensitive handling after the original event and there are also instances where a doctor may not have done anything technically wrong but may have generated enough ill-feeling to provoke a complaint.[8] As previously discussed, claimants are motivated not only by a desire for an explanation, a wish for retribution, and the need for compensation, but also by concerns about standards of care. Both patients and relatives

[3] M Brazier and E Cave, *Medicine, Patients and The Law*, 5th edn (Harmondsworth, Penguin, 2011) 6.
[4] Part II Medical Negligence Litigation above.
[5] Ibid.
[6] E Cave, 'Redress in the NHS' (2011) 27 *Professional Negligence* 3, 138-157 at 157.
[7] *Listening and Learning*: the Ombudsman's Review of Complaint Handling by the NHS in England 2010-11 at 26-28 has complaint handling subject keywords and percentages. I will discuss these below.
[8] L Mulcahy, 'Threatening Behaviour? The Challenge Posed by Medical Negligence Claims' in Freeman and Lewis (n 8) (eds) *Law and Medicine: Current Legal Issues* vol 3 (Oxford University Press, 2000) 98.

want to prevent similar accidents happening in the future and believe that staff or the organisation should have to account for their actions.[9]

Patients who are dissatisfied with their medical treatment will not necessarily either choose, or be eligible to pursue, an action in negligence. Such patients may nevertheless want to complain about the care they received.[10] A number of procedures exist to ensure that medical practitioners and healthcare providers can be held accountable for their actions. If a doctor's[11] conduct gives rise to concern it can lead to:

(a) a patient complaint to the health service provider
(b) litigation by a patient
(c) disciplinary action by the employing body
(d) after exhaustion of the complaints procedure, an investigation by the Health Service Commissioner (the Ombudsman)
(e) investigation by the General Medical Council (GMC) or
(f) in extreme cases, investigation by the police or, where death results, an inquiry by the Coroner and
(g) in exceptional circumstances there could also be a public inquiry.

After preliminary discussion of the context within which medical errors occur, I will briefly touch upon the regulatory processes and investigative recourse available to aggrieved patients and/or their relatives. This is followed by a detailed analysis of the history and working of the NHS complaints processes and the role of the Health Ombudsman.[12] In the Ombudsman's report of 2005,[13] Ann Abraham listed what she thought the essential elements for a new system for complaints should be. It would be essential, *inter alia*, to offer coherent and comprehensive coverage; to be customer focused which included issues of accessibility, flexibility and transparency; to offer a quality service including the NHS being open and transparent about mistakes; to offer effective complaint handling with links to clinical governance; and finally to offer a

[9] Ibid. See page 98 footnotes 45 and 46 therein; and C Vincent, M Young and A Phillips, 'Why do People Sue Their Doctors? A Study of Patients and Relatives taking Legal Action' (1994) 343 *Lancet* 1609-13. Also Chapter 2 'What Patients Seek from Redress', above.
[10] E Jackson, *Medical Law* 2nd edn (Oxford, Oxford University Press, 2010) 141.
[11] This discussion also includes members of the healthcare team.
[12] Hereafter 'the Ombudsman'.
[13] Ann Abraham, The Health Service Ombudsman for England, 'Making Things Better? A Report on Reform of the NHS Complaints Procedure in England' HC 413 (London, The Stationery Office, 9 March 2005) ch 3 'Key Elements of a New System'.

system of just redress. Redress should include provision for a full range of remedies for justified complaints, including explanations, apologies, specific actions or treatment for the patient, changes to prevent recurrence, and, where appropriate, financial compensation. The Ombudsman concluded that a just redress should be designed to put the complainant back in the position they would have been in had the service failure or maladministration not occurred; or if that were not possible, to compensate them appropriately.

I will show that in its present form and operation the complaints system falls far short of these aspirations. Ideally, the NHS complaints system was envisaged not as a fall-back when litigation was not possible but as an avenue to address different problems such as explanations of the adverse event and plans to avoid recurrence. Whereas litigation offers damages for specific losses,[14] I have argued that damages cannot appropriately address issues of intangible loss such as pain, suffering, loss of amenity and other loss associated with iatrogenic harm. The complaints system in its present structure is not designed to offer significant financial redress. Although the Ombudsman can recommend that financial recompense be made to cover expenses that the patient has incurred as a result of the faults found, she does not award financial compensation.[15]

The complaints system as it operates at present is failing in its core role of offering open disclosure and learning from mistakes.[16] I will measure the current complaints system against the Ombudsman's essential elements for a just system of redress. After analysis of the history and current form of the NHS complaints process, I will conclude with a discussion of the recommendations of the House of Commons Health Committee[17] for the future shape of the complaints process and the redress for iatrogenic harm it may offer complainants. On the positive side is the Ombudsman's and Health Committee's commitment to a well-functioning complaints process. The unfinished work is to translate this into reality.

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[14] Chapter 6 'Damages', above. Where patients have suffered significant financial loss, ie, loss of earnings and/or future care, the proper route would be litigation. When patients state a preference for explanations and apologies over compensation, I suggest they are referring to intangible loss.
[15] G Aldous (ed), *Clinical Negligence Claims: A Practical Guide* 2nd edition (London, Chambers of G Aldous QC, 9 Gough Square, 2011) 46.
[16] House of Commons Health Committee (Hereafter: Health Committee), 'Complaints and Litigation' Sixth Report of Session 2010-12 Printed 22 June 2011. Avoiding recurrence of the adverse event for other patients was the most mentioned motive for complaints by injured patients. See Chapter 2 'What Patients Seek from Redress' above.
[17] Ibid.

A. Medical Error in Context

Few professionals still stand so high in the public esteem as doctors and nurses[18] but this comes at a stiff price. Though their triumphs garner great praise, few individuals attract greater public condemnation than the doctor or nurse who errs. The price of the power wielded by medical professionals is that those who exercise it must expect to be subjected to constant scrutiny from patients, their families and the public at large.[19]

1. Historical Backdrop: 'The Times They Are a-Changin'

The Ancient Greek model of clinical autonomy was that of a doctor as a beneficent paternalist, in sole possession of specialist skills and knowledge. The only constraints on the individual doctor's freedom of action were those imposed by the medical profession itself, in line with its perception of the best interests of the patient.[20]

A wonderful description of the exalted position of consultants in 1930s England, before the founding of the National Health Service, is that of Nicholas Timmins:[21]

> The British Medical Association was meeting in the Great Hall of BMA House in Tavistock Square, a massive neo-classical, red-brick building originally designed by Sir Edwin Lutyens for the Theosophical Society with the Great Hall as its temple. The Society had been unable to afford the mighty edifice which came to symbolise all the self-important solidity the medical profession felt was its right – a building where, as late as the 1930s, the clerical staff were under instruction not to share the lift with the great London consultants who arrived to do their business in top hats and frock coats.[22]

Although this model was largely unchallenged for millennia, legislative and judicial developments during the second half of the twentieth century have introduced greater concern for the autonomy of the patient and, as will be seen below, the most recent trends threaten to circumscribe the doctor's traditional and jealously guarded freedom to practise with the minimum of external intervention. The first major change to the doctor-patient power relationship in England came with the advent of the NHS.

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[18] R Tallis, *Hippocratic Oaths: Medicine and Its Discontents Great Britain*, (London, Atlantic Books, 2004), 102.
[19] Paraphrased from Brazier and Cave (n 3), 4-7 and discussed therein at length.
[20] ED Pellegrino and DC Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (Oxford, Oxford University Press, 1987) 3.
[21] N Timmins, *The Five Giants: A Biography of the Welfare State* (London, Harper Collins, 2001) 103.
[22] E Grey-Turner and FM Sutherland, *History of the British Medical Association Volume II 1932-1981* (London, BMA, 1982) 3.

The NHS opened for business on 5 July 1948. Prior to this, access to healthcare for most of the population was patchy and limited. However, the most important thing the NHS did was to take away fear. Before it, millions at the bottom of the pile had suffered untreated hernias, cancers, toothache, ulcers, and all kinds of illnesses rather than face the humiliation and worry of being unable to afford treatment. There are many moving accounts of the queues of unwell, impoverished people surging for treatment in the early days of the NHS, arriving in hospitals and doctors' waiting rooms for the first time 'not as beggars but as citizens with a sense of right.'[23]

The next quantum leap for patient empowerment was 'The Citizen's Charter',[24] an initiative by the Government to improve the quality of public services and make them responsive to their users. Principles of public service such as the maintenance of proper standards were made express goals, and the citizen could legitimately expect service of a certain quality, with legal consequences for failure to honour statements of policy or intention.[25] Of particular note is that one aspect of this initiative was the establishment of adequate internal complaints procedures. Such procedures were expected to be well-publicised, open and accessible and were to provide clear information on how to complain and, if dissatisfied with the internal response, to give patients recourse to the Parliamentary or National Health Services Commissioners.[26] The most recent legislation underpinning patients' rights is, of course, the Human Rights Act 1998.[27] It is telling that the influential organisation Action for Victims of Medical Accidents (now known as Action against Medical Accidents (AvMA), using the language of rights, has emphasised that patients have 'The Right to Know - a Fundamental Right,' and the 'Right to Redress' embodied in its charter.[28]

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[23] A Marr, *A History of Modern Britain* (London, Macmillan, 2007) 67.
[24] *The Citizen's Charter: Raising the Standard* CM 1991. The Patients Charter 1991, revised 1995, was abolished as part of the ten-year plan for reform: Department of Health, *The NHS Plan: a plan for investment, a plan for reform*, CM 4818 (Crown Copyright, 1 July 2000). See also *The Citizen's Charter-Five Years On* (HMSO 1996) setting out new NHS Commitments.
[25] Ibid, 370.
[26] Health Service Commissioners Act 1993 as amended by the Health Service Commissioners Act (Amendment) Act 1996, 107.
[27] See CJ Lewis, *Clinical Negligence* 6th edn (Haywards Heath, Tottel Publishing Ltd, 2006), ch 27, 445-463. Relevant articles of the HRA 1998 will be discussed below as appropriate.
[28] P Walsh, 'Medical Error, the Law and Alternative Approaches' (2007) 75 *Medico-Legal Journal* Pt 2, 40, 44. Also see Lord Irvine, 'The Patient, The Doctor, Their Lawyers and The Judge: Rights and Duties' (1999) 7 *Medical Law Review* 3, 255-268 anticipating the focus on patients' rights with the advent of the Human Rights Act 1998.

In addition to legislation, the attitude of the judiciary towards the medical profession has also changed. Recently, there has been a marked increase in the number of cases coming before the civil courts involving the medical profession.[29] This development must be seen against a background of a more consumerist, and arguably more litigation-prone population and the rapid progress that has been made in medical technology. Claims for medical negligence have given rise to increasingly complex factual issues for the courts to resolve. Most striking of all has been the development of an almost new medical jurisprudence involving complex and emotive issues but issues which have often been as much about ethics as the law.[30] Attitudes are changing within and without both the legal and medical professions. Although historically the courts have been reluctant to appear to trespass on the expertise of another senior profession, the courts are being more proactive in recognising circumstances in which practices considered appropriate by a body of doctors may not always be the benchmark by which a doctor's actions must be judged.

With this very brief history, one can see that, during the lifetime of the NHS, the climate within which medical error is now viewed has changed from one of excessive deference to medical opinion to one of critical analysis and regulation. Vocabulary has also changed and it is time to define medical error.

2. Medical Error Defined[31]

To be clear from the outset, I am here looking at iatrogenic harm,[32] which is unintentional and due to medical error. Error is an essentially contested concept, particularly in complex and uncertain fields such as medicine. Much lies between the two extremes of blame-free accident and deliberate harm, and this is reflected in the

[29] In 2009/10, the National Health Service Litigation Authority (NHSLA) received 6,652 claims for clinical negligence – over 500 more than the previous year. NHSLA *Reports and Accounts 2010* HC 52 (London, 2010). See Cave (n 6), Mulcahy (n 8), and O Quick, 'Prosecuting "Gross" Medical Negligence: Manslaughter, Discretion and the Crown Prosecution Service' (2006) 33 *Journal of Law and Society* 3, 421-50 at 426.

[30] Lord Irvine (n 28), Lord Woolf, 'Are The Courts Excessively Deferential To The Medical Profession?'(2001) *Medical Law Review* 1-16. See also *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582 and *Bolitho v City and Hackney Health Authority* (1993) 4 Med LR 381 Lord Irvine's comments about the tension between *Bolam* and the needs of pioneering doctors, at 267 and Chapter 4 'Proving Clinical Negligence: Duty and Breach' above.

[31] This is based on O Quick, 'Outing Medical Errors: Questions of Trust and Responsibility' (2006) 14 *Medical Law Review* 1, 22.

[32] A Merry and A McCall Smith, *Errors, Medicine and The Law* (Cambridge, Cambridge University Press, 2001) have called for a distinction between errors and violations, where only the latter involves moral culpability.

myriad of terms competing to describe the phenomenon of error in medicine: 'accidents', 'mishaps', 'errors', 'negligence', 'failures', 'incompetence', 'misconduct', 'malpractice', 'deficient or substandard care', 'adverse or untoward events' and the concept of 'iatrogenic harm'. In addition, particularly serious incidents may warrant the label 'disaster'.[33] Semantics matter. The different meanings and connotations of these terms are not without significance. 'Accident' conveys a neutral, blame-free meaning unattached to notions of responsibility and liability.[34] Accidents are regarded as matters of fate which excuse participants from censure. With greater knowledge about the history of such events, the notion of an innocent unpredictable 'accident' is increasingly being rejected. Reflecting this, the term has been abandoned in other settings, such as traffic safety,[35] and the British Medical Journal has banned it from its pages.[36] 'Adverse events' are described as injuries arising from medical intervention, not the underlying condition of the patient. According to this definition, they are unexpected yet avoidable. The terms 'mistake' and 'error' imply a wrong act and convey a negative judgemental meaning. Similarly, 'negligence' carries with it 'at least an innuendo of moral blame'.[37] The term 'mishap' falls somewhere between 'blame-free accidents' and 'blameworthy errors'. Neither innocuous nor inflammatory, this term might be the most appealing to both public and profession. In this chapter 'error' is a generic term encompassing all failures to achieve intended outcomes that cannot be explained by chance.[38]

There has been a paradigm shift in terms of thinking about errors.[39] In the aftermath of the disasters, the lens of responsibility is being refocused away from people and towards (work) places. Institutions, not individuals, processes rather than persons are becoming the focus of investigation. This is reflected in the formal responses to these events, such as public inquiries, which now routinely focus on system responsibility. While systems analysis has obvious merits, it also raises important and unresolved questions. In particular, what are the implications for individual professional responsibility? And what does this mean in terms of the search for justice?[40]

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[33] BA Turner and NF Pidgeon, *Man Made Disasters* 2nd edn (Oxford, Butterworth-Heinemann, 1997) 19.
[34] The traditional concept of a pure accident is an unmotivated, unforeseen event, distant from wilful damage and neglect. For fuller explanation: Quick (n 31) 22.
[35] L Evans, 'Medical Accidents: No Such Thing?' 307 *British Medical Journal* (1993) 1438.
[36] R Davis and B Pless, 'BMJ Bans Accidents' (2001) 322 *British Medical Journal* 1320.
[37] P Devlin, *Samples of Lawmaking* Oxford University Press (1962) 100. Certain errors may be classified as negligent: *Whitehouse v Jordan* [1981] 1 All ER Lord Edmund-Davies 267 at 276.
[38] See Quick (n 31) 22 and K Oliphant, 'Defining 'Medical Misadventure': Lessons from New Zealand' (1996) 4 *Medical Law Review* 1, 1.
[39] Quick (n 31) 14.
[40] See Chapter 1 'Corrective Justice and Entitlement to Redress within the NHS' above.

In the interpretation of adverse events, the stakes are high for both patients and doctors. What is emerging is an eroding of the, perhaps misplaced, unconditional trust that the general public and patients appeared to have invested in their doctors. Although patients are thereby empowered, citizens rather than supplicants, this loss of trust is not an unalloyed good and comes at a price that merits consideration.

Negligence claims have the potential to threaten the medical profession in a number of ways. They can expose doctors to external scrutiny by colleagues, solicitors, barristers, and the judiciary and increasingly to managers within the Health Service with responsibility for overseeing claims and risk management. It is clear that public knowledge about medical errors has increased markedly in recent times. Errors are no longer closeted in the private professional domain.[41] Whether or not a claim has actually been received by a doctor, the fear of litigation may encourage him to adopt risk-aversive strategies such as defensive medicine[42] or the avoidance of high-risk specialities. Additionally, the high costs of some claims and the fact that these are now met from local budgets may expose doctors to pressure from managers to manage the claims in a way not acceptable to them. Where they see the allegations as justified, doctors may have to come to terms with their own incompetence. At the very least they will have to come to terms with a breakdown in the relationship with a patient.[43]

The making of a claim can also prompt a personal crisis for the doctor because it challenges the core assumption that healthcare professionals heal or alleviate pain.[44] Research suggests that doctors are not well supported in their plight by medical colleagues or by the normative frameworks of the profession into which they are socialised in medical school. Many suffer severe reactions to having a claim made against them and in coming to terms with medical mishap. Authors of recent large-scale studies of error in medicine suggest that the incidence of mishap is high and that intense reactions to these events have to be understood within the concept of the 'perfectibility model' to which doctors are taught to aspire in the course of their education. They are

[41] See Quick (n 31) 22 for a detailed discussion regarding the 'outing' of medical error and the need for further systematic research.
[42] 'Defensive medicine' includes excessive investigations.
[43] Walsh (n 28) 43 suggests that the breakdown of doctor-patient relationships in these situations is avoidable but it is submitted that that proposition takes insufficient note of human nature.
[44] Mulcahy (n 8) 82-87 especially 86 fn 25 for research studies.

socialised in medical schools to strive for error-free practice.[45] Although discussion of this phenomenon is outwith the remit of this thesis, understanding the psychological sequelae of litigation to doctor and claimant is crucial to any evaluation of redress for alleged clinical negligence.

'Passion is never far away from every-day relationships between doctor and patient.'[46] One reason for this could be that the patient looks to the physician as a healer, an archetype, someone who has the knowledge and magic that will bring relief from fear and pain.[47] Concerns about errors and public safety fall within the broader themes of risk and trust in experts and expert systems. Exposure of errors to a critical public audience presents problems for the professional, in particular, the risk of diminishing trust. Heightened awareness of errors potentially undermines trust in medicine.[48] Given that the practice of medicine depends upon a collaborative effort between doctor and patient, loss of trust would greatly undermine the efficacy of treatment. Patients need to have confidence in the larger system by which doctors are held to account.

Research on the incidence of medical mishap has demonstrated that medical error and mistakes are common[49] and this has provided an incentive for the introduction of more stringent risk management and clinical audit protocols.[50]

B. Regulation and Investigation

The NHS complaints system does not operate in a vacuum. It functions within the context of regulatory and investigative processes. Although my thesis focuses on the NHS complaints system, for completeness I briefly refer to these systems and what they can offer harmed patients.

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[45] Ibid.
[46] Brazier and Cave (n 3), 6.
[47] Lewis (n 27) 1.
[48] Quick (n 31), O O'Neill, *A Question of Trust: The BBC Reith Lectures* (Cambridge, Cambridge University Press, 2002) and O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge, Cambridge University Press, 2002).
[49] Mulcahy (n 8) 100 fn 52. Tallis (n 18) 102 and Quick (n 29).
[50] V Harpwood, 'The Manipulation of Medical Practice' in Freeman and Lewis (eds) (n 8), 50 and more recently Aldous (n 15) chs 1 and 2.

1. Regulation: Doctors and Hospitals

a) The General Medical Council:[51] *Quis Custodiet Ipsos Custodes?*

Professional regulation is of paramount concern for those claimants seeking sanctions against their doctor.[52] Reforms (and reform proposals) of the GMC introducing licences to practise[53] and, by 2012, revalidation[54] and reforming fitness to practise proceedings,[55] have been well received.[56] The powers of the GMC, in ascending order of seriousness, are: to give a formal warning that will last for five years; to impose conditions on the practitioner's registration; to suspend the practitioner for a maximum of twelve months; and to erase the practitioner's name from the register.[57] The primary objective in imposing sanctions concerns the wider public interest and the impact on the practitioner, while relevant to proportionality, is not a primary consideration.[58] In conclusion, although patients do not receive financial compensation or full disclosure in relation to events by the mechanism of a referral to the GMC, they have a measure of reassurance knowing that the public is being protected from impaired doctors.[59]

b) Clinical Governance

Whereas the issues mentioned above regarding the GMC refer to the regulation of individual doctors, the question of clinical governance is equally concerned with the

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[51] Hereafter 'GMC'. By virtue of the Medical Act 1983, the regulation of the medical profession is currently entrusted to the profession itself, acting through the GMC.
[52] Refer to Chapter 2 'What Patient Seek from Redress' above.
[53] The General Medical Council (License to Practise) Regulations Order of Council 2009, SI 2009/2739.
[54] GMC, CMOs and Medical Director of NHS, *Revalidation: A Statement of Intent* (2010), now streamlined and 'watered down' in Ministerial Statement, HC Deb, 26 July 2010 c65-6WS.
[55] GMC (Fitness to Practise) (Amendment in relation to standard of proof) Rules Order of Council 2008, SI 2008/1256; GMC (Fitness to Practise) (Amendment) Rules Order of Council 2009, SI 2009/1913. Quoted in Cave (n 6) at 147. But see also P Case, 'The Good, the Bad and the Dishonest Doctor: The General Medical Council and the "Redemption Model" of Fitness to Practice' (2011) *Legal Studies* 31 591-614.
[56] Council for Healthcare Regulatory Excellence (CHRE), *Fitness to Practise Audit Report* (2010), p 27, which labels the GMCs fitness to practise procedures robust and effective. Quoted in Cave (n 6) at 147. But see also Case (n 55).
[57] Aldous (n 15) 13. Note practitioner's right of appeal.
[58] *Robert Alan Odes v General Medical Council* [2010] EWHC 552 (Admin.).
[59] M Timms, 'Referring a Doctor to the General Medical Council' (2006) *Journal of Personal Injury Law* 36-39, 36. Note: Where there has been a systems failure which may be sufficient to warrant a finding of negligence against an NHS Trust or hospital, when the role of an individual doctor in the systems failure is analysed, it may not be sufficient to warrant a finding of impairment. See I Kennedy, A Grubb, J Laing, and J McHale, *Principles of Medical Law* 3rd edn (Oxford, Oxford University Press; 2010) ch 2 'Regulating Healthcare Professionals' for a fuller account of the GMC.

regulation of NHS organisations. As a person now outside the regulatory system,[60] it appears to me that the regulatory system is failing profoundly. There are daily news reports of significant harm to vulnerable patients such as the elderly.[61] The Care Quality Commission (CQC)[62] which has been charged with responsibility for public accountability[63] has 'not so far achieved value for money in regulating the quality and safety of health and adult social care in England' according to the National Audit Office.[64] This is a matter of concern for all of us involved in a universal welfare system.

NHS governance has been profoundly affected by Professor Sir Ian Kennedy's 'Bristol Report' *Learning from Bristol*[65] which recommended that clinical audit should be at the core of a system of local monitoring of performance. Since that time there has been a bewildering array of reforms designed to enhance and monitor quality in the NHS.[66] The CQC is now the independent regulator of all healthcare and adult social care in England. It registers providers of health and social care, monitors compliance with standards, investigates areas of concern, has enforcement powers if services drop below essential standards, including the power to close a service down, acts to protect patients whose rights are restricted under the Mental Health Act 2007, and gives the public information about the work done.[67] The CQC does not have a role in resolving complaints[68] but does liaise with the Ombudsman.[69] The National Audit Office report referred to above[70] noted that there is a gap between what the public and providers expect of the CQC and what it can achieve as regulator. Additionally, proposals to extend the Commission's role risk distracting the Commission from its core work of regulating health and social care.[71] Discussion of the CQC is outwith my remit;

[60] I was Chair of Independent Review Panels from 1996 until their cessation.
[61] *Care and Compassion:* Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People February 2011.
[62] Hereinafter 'CQC'.
[63] Cave (n 6) at 146.
[64] CQC, *Regulating the Quality and Safety of Health and Adult Social Care* at www.nao.org.uk/publications/1012/care_quality_commission.
[65] *Learning from Bristol: The Report of the Bristol Inquiry into Children's Heart Surgery at Bristol Royal Infirmary, 1984-95* (Cm 5207, 2001) hereafter *The Bristol Inquiry.* See the account of the Clinical Governance in Kennedy et al (n 59) ch 1 'Organisation of Healthcare' 77.
[66] Brazier and Cave (n 3), 25.
[67] Aldous (n 15) 4.
[68] Jackson (n 10) 142.
[69] *Listening and Learning* (n 7) 2010-2011, Foreword.
[70] CQC (n 64).
[71] Ibid.

however, its shortcomings matter because it is the body with powers to enforce rather than simply recommend.[72]

In conclusion, the foregoing has been a consideration, first of medical error and then of the current regulation of the medical and healthcare systems. The next question to be addressed is from the perspective of the aggrieved patient and/or their family who are inquiring into the details of the adverse event. The issue then becomes an evidential one.

2. Investigation

What do patients or bereaved relatives want when things go wrong? What the vast majority want is firstly an apology or an explanation; additionally they usually want to find out what has happened, so as to understand and, if possible, come to terms with it; and finally, they may want an inquiry into what has gone wrong so as to prevent others in future suffering the same sequence of events or procedural errors which led to their harm.[73] To this end, there are two major avenues which offer investigative processes; namely, an inquest in the coroner's court,[74] confined to post-death investigations, and public inquiries. Both topics are complex and require careful study. As they are beyond my remit, I confine myself to noting these mechanisms in place for dealing with deaths and public interest issues.

a) Inquests

Inquests, as the word suggests, are inquisitorial in nature and are not adversarial proceedings. Their purpose is to establish the facts and provide an explanation of a death. The proceedings and evidence at an inquest are directed solely at ascertaining who the deceased was; how, when and where he/she came by his/her death; and the particulars required by relevant legislation to be registered concerning the death.[75] The coroner and jury are prohibited from expressing any opinion on any other matters.[76] An inquest does not seek to establish criminal or civil liability. Indeed rule 42[77] specifically prevents a verdict being framed in such a way as to appear to determine any question of

[72] Brazier and Cave (n 3), 253.
[73] Lord Woolf (n 30) 15. Walsh (n 28).
[74] See Kennedy et al (n 59) ch 22 'Death' at 1155 and Aldous (n 15) 117 for full exposition.
[75] Coroners Rules 1984 rule 36 (1). Aldous (n 15) 117.
[76] Coroners Rules 1984 rule 36(2).
[77] Coroners Rules 1984.

criminal or civil liability. Nevertheless, if an inquest is held, relatives of the deceased should find out what the hospital/health provider says about the circumstances surrounding the death. While an inquest is not a trial and cannot apportion guilt to any individual,[78] it relies upon the discretion of the coroner as to what questions may be asked, or witnesses approached; nevertheless, with the possibility of a narrative verdict, the inquest is a major resource in the armoury of the family seeking answers. The outcome of an inquest may provide an indication of whether to proceed to a civil action. If the circumstances of the death mean that the procedural requirements of ECHR Article 2 are engaged, funding may be provided for legal representation for the family to effectively and actively pursue such answers as it seeks.[79]

b) Public Inquiries

When things go wrong in the NHS, an inquiry is often set up to find out what happened and what can be learnt. In the past few years, the NHS has been subject to several major inquiries. Such inquiries have been established to investigate poor clinical performance, major service failure and criminal misconduct. They have become an increasingly common political and managerial response to any major problem in the NHS.[80] A comprehensive discussion of inquiries is outwith the present remit; however, I am highlighting relevant details of inquiries because of their significance in the landscape of health investigations. In recent years, medical disasters[81] have increasingly been followed by public inquiries which have both investigated the causes of these tragedies and made recommendations as to how similar adverse events might be avoided in the future. An NHS inquiry may be established under section 2 of the National Health

[78] Coroner Rules 1984, rule 42.
[79] An example of the interaction between inquests and inquiries can be seen when the inquest into Dr D Kelly's death by the Oxfordshire Coroner had been adjourned while the inquiry proceeded. This was one of four occasions when inquests have been adjourned under s. 17A of the *Coroners Act 1988* pending the outcome of public inquiries (HC Deb 10 July 2006, c1617W). The inquest was not reconvened.
[80]See K Walshe, and J Higgins, 'The Use and Impact of Inquiries in the NHS' (2002) 325 *British Medical Journal* 7369, 895-900 for fuller exposition and listing of inquiries.
[81] the Bristol Inquiry (n 65). Interim Report, *Removal and Retention of Human Material (*www.bristolinquiry.org.uk). *The Royal Liverpool Children's Inquiry Report* (2001) HC 12-11 (the Redfern Report). *The Shipman Inquiry* (www.the-shipman-inquiry.org.uk.) and Healthcare Commission, *Investigations into Mid Staffordshire NHS Foundation Trust* (Newcastle, Healthcare Commission, 2009). See Brazier and Cave (n 3) 3 footnotes 1-10 for a comprehensive list.

Service Act 2006.[82] However, NHS inquiries tend to be informal and lack coercive powers.[83]

Public inquiries pursue important goals which cannot be achieved by other means, Parliamentary or judicial. Increased recourse to the public inquiry can be understood in the context of a decline in trust in previously revered institutions. Trust is a 'notoriously vulnerable good, easily wounded and not at all easily healed'.[84] The medical setting is full of potential for trust to be eroded, and the Shipman and Bristol disasters are graphic illustrations of this. There is, however, a parallel rise of faith in public inquiry as somehow being the only mechanism for dealing with tragedy. In the medical arena, despite a multi-layered system for responding to serious mishaps and misconduct, the call for a public inquiry sits at the top of the agenda. Its perception as the only forum for discovering the truth is unsurprising, given the frustration with the outcomes of disciplinary hearings of self-regulatory bodies. Clamour for public inquiries also fits with the gradual shift from secrecy to openness.[85] There are many advantages associated with public inquiries. Thoroughness in gathering facts and pursuit of the truth distinguishes the public inquiry from the narrow scope of legal proceedings. The openness and transparency of such inquiries offer the best way of restoring trust in the NHS. Public inquiries enable the exploration of broader issues, paving the way for regulatory and policy changes. An example of the effect of previous medical inquiries is the cessation of heart transplant operations and the request to the Healthcare Commission for an external review after a sudden rise in unexplained deaths in Papworth Hospital.[86]

Nonetheless, there are caveats regarding public inquiries, not least the vast expense and time involved in holding inquiries. The primary output of most inquiries is a report, usually lengthy and with many recommendations. In view of the fact that governments are not compelled to implement inquiry recommendations, such efforts may be frustratingly futile. In relation to due process, although individual reputations and public safety may be affected, inquiries do not give rights in relation to such matters as legal

[82] Formerly National Health Service Act 1977, s2.
[83] Brazier and Cave (n 3), 245. But see the provisions of the Inquiries Act 2005 regarding statutory inquiries.
[84] AC Baier, (1994) *Moral Prejudices: Essays on Ethics,* London, Harvard University Press 130. See also Medical Error Defined above.
[85] *R v Secretary of State for Health ex parte Wagstaff* (2001) 1 WLR 292*; R v Secretary of State for Health ex parte Associated Newspapers Ltd* The Times*,* 31 August 2000 (QBD).
[86] 20 January 2008 Daily Mail.

representation, cross-examination or appeal.[87] The adversarial model of procedural fairness depends, amongst other things, on notice, disclosure, confrontation, cross-examination and a reasoned decision. Witnesses are not always provided with prior disclosure of the criticism that they will face. Despite assurances that inquiries are not courts of law, it is claimed that for those giving evidence, it feels like a court without the procedural safeguards.[88] The fact that evidence is now publicly available on inquiry websites increases witness vulnerability and anxiety. Judicial review challenges might address this problem.[89]

For the injured and bereaved relatives, public inquiries can provide necessary evidential information. Investigation into the causation of damage in complex medical negligence cases can be a formidable burden for an injured person or bereaved relatives to have to arrange, let alone finance, as in cases of medical mishap publicly funded assistance is unlikely to be available.[90] However, although the findings of public inquiries can profoundly affect the course of subsequent negotiations, they can also be a source of frustration and delay, especially if a number of different inquiries take place: public inquiry, police inquiry and inquests.[91] As the increased scrutiny of medical work inevitably exposes further mishaps and misconduct to the public gaze, calls for inquiries are unlikely to abate. However, as inquiries become increasingly commonplace, it will be legitimate to question their effectiveness as a mechanism for enabling lessons to be learnt.

c) Conclusion: Regulation and Investigation

As has been seen above, when injury results from medical treatment, patients or their relatives seek accountability. This can take a number of forms. Some may wish the responsible health professionals to be disciplined, and this has been examined in the section on medical regulation. Some seek financial compensation and bring a medical negligence claim following the legal route to redress.[92] In particularly serious cases of

[87] O Quick, 'Cases' (2001) 23 *Journal of Social Welfare and Family Law* 1, 79-92.
[88] Ibid.
[89] Ibid.
[90] See Chapter 3 'Funding Litigation' above. Also P Cane, *Atiyah's Accidents, Compensation and the Law* 7th edn (Cambridge, Cambridge University Press, 2006) 111.
[91] Ibid 275. The *Marchioness* pleasure boat case prompted calls for a simplified inquiry process involving just one inquiry, possibly with adjudicative powers. S Sedley, 'Public Inquiries: A Cure or a Disease?' (1989) 52 *Modern Law Review,* 469.
[92] See Part II 'Medical Negligence Litigation' above.

repeated error or bad practice, patients often demand an inquest and/or a public inquiry. However, the starting point for all these matters is that an explanation is sought and it was for this that the NHS complaints procedure was originally devised.

II. THE WORLD OF COMPLAINTS

A. Introduction

Sir Michael Davies, in his 1973 Report of the Committee on Hospital Complaints Procedure writes:

> Complaint need not and ought never to be regarded as a dirty word[93]…Few have any serious grievances, but those who do have the legitimate right, no less, to have their dissatisfaction fully and fairly investigated. Furthermore, valid complaints which, at the present time, may remain unexpressed because of lack of knowledge of procedure, inadequacy of intellect or drive, fear of victimisation or for any other reasons, are much better brought out and dealt with than left to fester…
>
> There is ample and convincing evidence that more complaints involve 'medical treatment and care' than anything else…There is equally strong evidence that these complaints are the most difficult of all to deal with and resolve satisfactorily, particularly those which, theoretically at least, could result in court proceedings. In former days the attitude to such complaints was too often 'Sue or shut up'. This attitude is by no means as prevalent as it was…but it still does exist in some quarters. There are, of course, cases in this category in which it is right and proper for a complaint to be resolved by legal proceedings, but we are convinced that there are many more cases where a complainant does not wish to take legal proceedings but still does want his complaint to be fully and fairly investigated. The evidence convinces us that the complainant is not often motivated by a desire for revenge or punitive damages. Almost always the complaint is made in terms of 'It shouldn't happen again to someone else'.[94]

These opening remarks of a report into hospital complaints procedures made over a quarter of a century ago, and as apt today as they were then, show how elusive the resolution of complaints remains. As discussed previously, a tangle of motives lies behind a patient's or family's decision to take legal action following medical injury, and money is only one of them.[95]

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[93] 'Complain' origin from med. L. *complangere* 'to bewail' or 'to lament' *Oxford English Dictionary* 11th edn (2004).

[94] Davies (n 1), Introduction at 4-6.

[95] See ch 2 'What Patients Seek from Redress' above, and M Bismark and EA Dauer, 'Motivations for Medico-Legal Action – Lessons from New Zealand' (2006) 27 *The Journal of Legal Medicine* 55. See page 55 footnote 1 for details of research.

These motives, which can be considered to represent a demand for some form of 'accountability', can be classified into four themes:[96] restoration including financial compensation or some other intervention to 'make the patient whole again'; correction, such as a system change or competence review to protect future patients; communication, which may include an explanation, expression of responsibility; apology and sanction including professional discipline or some other form of punitive action. In the United Kingdom, one study[97] surveyed 227 patients and relatives who were taking legal action through firms of complainant medical negligence solicitors. In open-ended responses to a question asking what the provider could have done after the incident that would have prevented the claim, explanation and apology were mentioned more than twice as often as compensation and ten times as often as disciplinary action.

Yet medical malpractice litigation essentially offers injured patients and their families only one form of redress: financial compensation. Thus the legal system is used for a variety of reasons, most of which it is not intended to serve. This remedial narrowness may constrain efforts to achieve meaningful malpractice reform and improve patient safety.[98] As will be discussed below, the NHS complaints procedures, in ever evolving forms, have had as their goal a non-financial means of making amends. Complainants should receive at least investigation and explanation, and where appropriate, an undertaking to repair. Nevertheless the literature is replete with examples of how the NHS complaints procedure has been failing patients, especially in terms of providing explanations for mistakes.[99] Apologies are not forthcoming and doctors are understandably reluctant to admit errors because of fear that the complaints process might lead to patients seeking compensation in the courts.[100] It is submitted that a thread running through the whole field of dissatisfaction with redress for personal injury is the asymmetry between the damage and the redress. The patient cannot be made whole again. As has been shown above, recourse for investigation and explanation of adverse incidents in the NHS may be had through requests for inquests and public inquiries.

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[96] M Bismark, E Dauer, R Paterson, et al 'Accountability Sought by Patients Following Adverse Events from Medical Care: The New Zealand Experience' (2006) 175 *Canadian Medical Association Journal* 889-94.

[97] Bismark and Dauer (n 95), 56.

[98] Ibid.

[99] Brazier and Cave (n 3), 243.
At best, patients might receive a letter from the Trust Chief Executive to the effect that 'we are sorry this happened to you'.

[100] English academics seem to be beguiled by the appeal of no-fault medical injury schemes. Brazier and Cave (n 3), 243 and Cane (n 90).

I will address the question of the complaints processes for redress within the NHS in terms of time-frames: the history, the present and the future.[101] I will begin with a brief overview of the history of the NHS complaints procedures followed by a description of the extant system. I will then consider the most recent Parliamentary recommendations for the future shape of an effective complaints procedure.[102] I will conclude with the Ombudsman's recommendations for an effective and just complaints system[103] and using these as a yardstick, analyse how far or otherwise we have come towards achieving this end.

B. Complaints Procedures: A Troubled History

A formal NHS complaints system was introduced in 1966. There were three separate schemes, relating to primary care, clinical care and non-clinical care respectively.[104] As early as 1973, the report of the Davies Committee[105] on hospital complaints criticised the complaints mechanisms for being too internal and based on general principles which were inconsistently applied. The Davies report, published some 30 years ago, was 'quietly interred…'.[106] The climate within which the NHS functioned changed. The particular focus given to consumers in the new, market-oriented, public services and the Citizen's Charter[107] initiative increased expectations. Spiralling complaints and overwhelming criticism that the NHS complaints system was fragmented, confusing, cumbersome and slow, and evidently unsuited to the reformed pro-competitive NHS, led to further review in 1994. The Wilson Committee was entrusted with the remit to review the current complaints procedures and to ensure that a new complaints process was effective from the perspective of both users and providers of health services. The review was wide-ranging[108] but the terms of reference excluded consideration of litigation or professional disciplinary matters. Nevertheless, the Wilson report

[101] Health Committee (n 16).
[102] The Redress Act 2006 will be addressed in Chapter 8 'The NHS Redress Act 2006 – A Lost Opportunity' and the issue of apologies will be addressed in the final Chapter 9 'Effective Redress' both below.
[103] Abraham (n 13) ch 4 Recommendations.
[104] For details and regulations of the system refer to M Mayberry, 'The NHS Complaints System' (2002) 78 *Postgraduate Medical Journal* 925, 651 and Brazier and Cave (n 3), ch 9 'Complaints and Redress'.
[105] Davies (n 1).
[106] C Webster, 'Why Has It Taken So Long To Achieve Too Little?' *Health Matters* Issue 26.
[107] *The National Health Service: A Service with Ambitions* Cmnd 3425 (1996). *The Citizen's Charter-Five Years On* (n 24) which sets out new NHS commitments. D Longley, 'Complaints After Wilson; Another Case of Too Little Too Late?' (1997) 5 *Medical Law Review* 172.
[108] Encompassing England, Wales, Scotland and Northern Ireland. See Longley (Ibid.) for details of the substance of the Wilson Report 'Being Heard'.

commented on the importance of the relationship between complaints and the latter two areas.[109]

In 1996, the Government accepted the principal recommendation made by the Wilson Committee and issued the final guidance along with statutory directions which set out the ground rules for the new system:[110]

(1) One single complaints procedure became applicable throughout the NHS. Hospital doctors, GPs and other community-based health professionals were dealt with within a unified complaints system.
(2) A three-step process was established so that complaints were first subject to 'local resolution' which could be followed by an 'independent review' of the case, with an ultimate right to resort to the Health Service Commissioner (known as the NHS Ombudsman).
(3) The NHS Ombudsman was finally empowered to investigate complaints about clinical judgment and his jurisdiction was extended to cover GPs.[111]

Although the revised NHS complaints system had laudable objectives, putting principle into action proved a harder task and dissatisfaction with the NHS complaints system endured.[112] Patients complained that the second stage was not truly independent and that the process was complex, time-consuming and inefficient. Doctors were perceived as defensive and mistakes were repeated. The complaints system was reformed in 1996, and again in 2003 and 2006.[113]

The single complaints system introduced in April 1996 was a radical improvement on a previously fragmented and partial system.[114] For the first time, the same complaints system covered hospital, community and primary care services, and could handle concerns about both administrative and clinical treatment. Complaints were first considered and responded to by the service provider, this first stage being known as local resolution. If complainants remained dissatisfied they could ask a convenor (usually a non-executive member of the organisation complained about) to arrange a

[109] '*Being Heard'* - The Report of a Review Committee on NHS Complaints Procedures (1994) DH (Hereafter *Being Heard*).
[110] Directions to NHS Trusts, Health Authorities and Special Health Authorities, (96)19 and Miscellaneous Directions to Health Authorities for Dealing with Complaints 96(23). National Health Service Executive, Complaints- Listening-Acting-Improving: Guidance on Implementation of the NHS Complaints Procedures (1996) DH. For precise details see Mayberry (n 104) 651.
[111] Brazier and Cave (n 3), 248.
[112] Select Committee on Health 6th Report, *Procedures Related to Adverse Clinical Incidents and Outcomes in Medical Care,* HC 549 (1999) and Longley (n 107).
[113] See Brazier and Cave (n 3), 249.
[114] Abraham (n 13) ch 1 'A Brief History of Proposals for Reform'.

review by a panel of lay people, with access to any necessary clinical advice.[115] This was known as the second, or independent, review stage. However there was no automatic right to such a review. Where complainants remained dissatisfied, or had been refused an independent review, they could complain to the Healthcare Ombudsman. In the evaluation of the effectiveness of the new system, the Department of Health[116] found that there was a high degree of dissatisfaction with both the local resolution and independent review stages. The main causes noted were unhelpful, aggressive or arrogant attitudes of staff, poor communication and a lack of information and support. The most important structural failure was the 'perceived lack of independence in the convening decision' and in the review process generally.[117]

C. The Extant Complaints Procedure[118]

1. From Three Stages to Two

Revisions were made in the National Health Service (Complaints) Regulations 2004,[119] which entrusted independent review to the Healthcare Commission. A number of major inquiries necessitated further reform. The Shipman Inquiry[120] and two private inquiries, the Neale and the Ayling Inquiries, considered the adequacy of the NHS complaints process. The fifth report of the Shipman Inquiry made recommendations for improvements to the system, especially in relation to general practitioners. The National Health Service (Complaints) Amendment Regulations 2006[121] were duly enacted to improve local resolution and to align the NHS and social care complaints systems. Problems persisted.[122] There were at least seven different routes for complaints about health services and many were poorly signposted.[123] Only 27 per cent of people making a complaint were satisfied in the way it had been handled. Further reforms were

[115] This was independent clinical advice and with the removal of this second stage, unless the complaint was accepted by the Health Ombudsman, access to free and independent clinical opinion was lost. I acted as a Lay Chair of Independent Review Panels from 1996 until the second stage was abandoned.
[116] Department of Health, *NHS Complaints Procedure: National Evaluation* (Crown Copyright, 2001).
[117] See Abraham (n 13) ch 1 'A Brief History of Proposals for Reform', for further details of reforms before the present system.
[118] Brazier and Cave (n 3), 248.
[119] National Health Service (Complaints) Regulations 2004 SI 2004/1768.
[120] *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, Cm 6394 (2004).
[121] The National Health Service (Complaints) Amendment Regulations 2006 SI 2006/2084.
[122] DH, *Making Experiences Count: A New Approach to Responding to Complaints* (2007) London; National Audit Office*, Feeding Back? Learning from Complaints Handling in Health and Social Care* (The Stationery Office, 2008).
[123] *Feeding Back?* Ibid.

announced in 2009[124] to make the process faster and more effective and to introduce a single complaints system across health and social care. Applicants now have the right to local resolution while simultaneously pursuing a legal claim.[125] The second stage of a three-tier complaints system was abandoned. Where previously a complainant would start with local resolution and potentially progress to the independent Healthcare Commission (replaced in 2009 by the CQC) and finally the Health Service Ombudsman, those dissatisfied with local resolution now go straight to the Ombudsman.[126]

2. Access to Justice via the Complaints Process

At a time when the Ministry of Justice is seeking to save £17 million by taking clinical negligence out of scope for legal aid[127] it is particularly important that patients worried about the possibility of iatrogenic harm have the ability to request information and explanation.[128] Although the complaints process is meant to be 'responsive to complainants' the mechanisms in place for access seem overly cumbersome. There is a distinction made between concerns and complaints.[129] To raise *a concern* the patient is directed towards the NHS Patient Advice and Liaison Service (PALS) which sees itself as an early warning system for NHS organisations and regulatory bodies by identifying problems or gaps in the services and reporting them.[130] However, the Health Committee found that in practice PALS offices are not always visible or signposted and that the staff were not at a sufficiently senior level within the organisation to influence clinicians and managers.[131] From PALS, a patient can then be referred to the Independent Complaints Advisory Service (ICAS),[132] which is a free and independent, confidential

[124] DH, *Listening, Responding, Improving – A Guide to Better Customer Care* (The Stationery Office, 2009).
[125] DH, *Clarification of Complains Regulations 2009* (2010) Gateway Reference Number: 13508, p2. The complaint may be put on hold if it might prejudice a legal claim.
[126] See Brazier and Cave (n 3), 251 for details of local resolution including who has standing to bring complaints and timeframe issues.
[127] See Chapter 3 'Funding Litigation' above; Right Honourable Lord Justice Jackson, *Review of Civil Litigation Costs: Final Report* (The Stationery Office, December 2009); and Health Committee (n 16) para 177.
[128] 'The Committee considers that preservation of access to justice will be the yardstick by which these proposals (legal aid funding) will be judged by the public and that the Government must take care to gauge its proposals against this measure'. Health Committee (n 16) para 180.
[129] Brazier and Cave (n 3), 249.
[130] 'What is PALS?', National PALS Network 24 December 2009, www.pals.nhs.uk
[131] Health Committee (n 16) 3 Advice and Advocacy Services.
[132] Established under Health and Social Care Act 2001, s 12; replaced by National Health Service Act 2006, s 248 but about to change and come under Local Authorities. See Brazier and Cave (n 3), 250 for details.

service designed to help patients and relatives make a complaint. ICAS can support patients with the practicalities of complaining and provide support to vulnerable complainants. There are, however, artificial boundaries that can impede this work. For example, ICAS cannot currently support patients to make complaints to the GMC or other professional regulators. The National Audit Office has suggested that awareness of ICAS services is very low. Their report into complaints handling in the NHS states that: '…84 per cent of dissatisfied NHS service users who did not complain were unaware of the ICAS service'.[133] ICAS services cost the taxpayer over £10 million per year[134] and the Health Committee recommends that greater emphasis must be placed on effective marketing and public information strategies.[135] My question is: *why is the complaints process perceived as so convoluted that it requires both a sifting process and then an independent advocate to aid troubled patients?*

I now turn to the role of the Health Ombudsman but will return to this issue thereafter.[136]

D. The Health Service Ombudsman

1. The Remit

The second and final stage of the NHS complaints system (complaining to the Health Service Ombudsman) is normally instigated only when the local resolution stage has been completed.[137] The Ombudsman undertakes independent investigations into complaints about NHS funded care and treatment brought to that office by complainants or their relatives. According to the Health Service Commissioners Act 1993, complaints may be made to the Ombudsman on the grounds of maladministration and/or poor service.[138] This being the case, a further two tests are applied before the Ombudsman accepts a complaint for formal investigation or intervention. Firstly, a person must have suffered injustice or hardship as a result of the poor service or maladministration and secondly, there must be a prospect of a 'worthwhile outcome'.[139] It is not usually possible to obtain damages, although in some rare circumstances, where the person

[133] *Feeding Back?* (n 122).
[134] *Listening and Learning* (n 7) 2009-10.
[135] See Health Committee (n 16) para 74 for further recommendations.
[136] See 'access to the complaints system' below.
[137] Health Committee (n 16) 2 'The NHS Complaints System'.
[138] Health Service Commissioners Act 1993, Section 3.
[139] *Listening and Learning* (n 7) 2009-10.

involved can prove that they have suffered financial loss, the Ombudsman can order some financial payment.[140]

The Ombudsman does not investigate cases where the complainant could bring an action for negligence unless it would not be reasonable to expect him to pursue a legal remedy. While this provision seeks to prevent 'fishing expeditions' it can lead to injustice where the complainant is unable to get legal aid and cannot afford legal action.[141] However, in some circumstances, the Ombudsman will take on complaints about negligent treatment, provided that the complainant undertakes not to start legal proceedings.[142] Such an undertaking is not legally binding and there is nothing to stop a complainant assuring the Commissioner he will not sue and then launching proceedings on the basis of the evidence uncovered by the Ombudsman.[143]

The Ombudsman has noted a significant increase in complaints proceeding to stage two of the complaints system. In 2009–10 complaints to the Ombudsman more than doubled on the previous year – a total of 15,579 complaints were closed in that particular year. Just over a half of these complaints (9,011) were closed because they had not completed the local resolution stage.[144] In essence then, the Ombudsman may carry out a formal investigation resulting in a detailed report about the case. Following this investigation the said detailed report will be sent to the complainant, the NHS organisation concerned and the Secretary of State for Health. There is no appeal against the Ombudsman's findings.[145]

2. The Challenges

Although the Health Committee accepted that 90 per cent of people were satisfied with the investigation carried out by the office of the Ombudsman, there were concerns at the small number of cases accepted for investigation.[146] The right to take one's complaint to the Ombudsman, if not satisfied by the NHS's local resolution,[147] rings hollow if the

[140] Ibid at 13 'Interventions made in 2009-10 resulted in 246 outcomes for complainants including payments for financial loss or inconvenience'.
[141] Jackson (n 10) ch 3 'Medical Malpractice' 'The complainant would need to show a strong case for a conditional fee arrangement.'
[142] Ombudsman Case W 241/79-80, HC 51 (1982-83).
[143] Brazier and Cave (n 3), 252. See at 220-222 for details of Ombudsman's remit.
[144] *Listening and Learning* (n 7) 2009-10 for figures.
[145] P Balen, *Clinical Negligence* (Bristol, Jordan Publishing Limited, 2008) 41.
[146] Health Committee (n 16) para 44. Note there was under reporting of the Ombudsman's actual work.
[147] Health Service Commissioners Act 1993.

case is not then taken up. More importantly, the Committee found that patients and the public perceive the Ombudsman as offering a general appeals process to the local stage of the complaints system, whereas the role is in fact much narrower than that. The Committee recommended that a complainant whose complaint is rejected by the service provider should be able to seek independent review. This is what was lost with the abolition of the second stage of review. The Committee also recommended that the operational and legislative framework within which the Ombudsman operates should be reviewed to make it effective for this wider purpose. The Ombudsman herself is dissatisfied with the quality of local resolution and poor complaint handling at local level.[148] Poor communication and staff attitude were mentioned both by the Ombudsman and the Health Committee Report and, most significantly, there are still insufficient mechanisms in place for learning from adverse events. The right to complain about NHS services and have one's complaint dealt with effectively is derived from legislation.[149] This shows a commitment to getting things right for patients but, as I discuss below, the commitment still awaits an effective process.

E. Nobody Knows the Trouble I've Seen: How to Fix It

1. The Problems

The NHS complaints procedure should provide redress in the forms of communication, correction, and potentially, sanction. These are the most noted requests for non-financial redress from patients and their families.[150] However, despite the aforementioned reforms, as Emma Cave reports, 'patients still found the complaints process inflexible, the system complex and slow and the healthcare professionals defensive and closed.'[151] The failure of the regulatory system to react quickly and effectively to appalling standards of care at Mid-Staffordshire[152] has led to further questions about the adequacy of the complaints process. There are evidently global problems with the complaints process.[153] However, for present purposes, I will highlight difficulties with access to the

[148] Ibid. and *Listening and Learning* (n 7) 2010-11, Foreword.
[149] Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
[150] Chapter 2 'What Patients Seek from Redress', above.
[151] Cave (n 6), 147.
[152] *Final Report of the Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust* (2010).
[153] Health Committee (n 16) 2 The NHS Complaints System at Summary.

system, problems with open and full disclosure, and a persisting lack of systematic learning from adverse events.

2. Access to the Complaints Process

I argue that the amorphous nature of what could be called a complaint is what prompted the establishment of the sifting mechanisms behind PALS and ICAS. The Health Committee acknowledged that 'it is always difficult for a single complaints system to manage complaints about the great diversity of issues that occur on a daily basis'. The Committee recommended that the Government consider carefully the development of separate systems for investigation and resolution of customer care complaints and more serious complaints about clinical issues. There should also be a stratified set of standards relating to each part of the system.[154] I think these proposals would go a long way to clarifying the nature of a complaint, thereby making resolution that much clearer. If the nature of the problem and redress available were clear from the outset, my argument is that it would then not be necessary for the PALS and ICAS[155] systems to be employed for access to the complaints system. This would free resources for Trusts and Central Government which could be better utilised.

3. Disclosure

Although, in the 2003 report of the Chief Medical Officer,[156] a formal duty of candour was proposed, it was clear to the Health Committee that the NHS does not always admit when things go wrong, nor does it always offer an explanation.[157] I have discussed the complex issue of disclosure and the nuanced way in which communication between doctor and patient can be distorted.[158] The Health Committee has placed great store in the role of the new commissioning agents as having the potential to drive improvement in the complaints system. Supportive of patients' expectation of full disclosure, the Committee suggests a contractual duty of disclosure between providers and commissioners. The Committee acknowledges that a culture change is also required but I think a contractual duty is a good first step. My reasoning is that a contractual duty is

[154] Ibid. Conclusions and Recommendations at para 7.
[155] There might still be a need for advocacy.
[156] Chief Medical Officer *Making Amends: A Consultation Paper Setting out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (Crown Copyright, Department of Health, 2003).
[157] Health Committee (n 16) 2 The NHS Complaints System at 77 and Cave (n 6) 148.
[158] Also see Chapter 2 'What Patients Seek from Redress' above.

the art of the possible whereas legislative reform has not been forthcoming. Even the NHS Redress Act 2006,[159] not yet implemented, did not include a statutory duty of candour.[160]

4. Learning from Adverse Events

The most-mentioned motive for both complainants and claimants is the desire 'that the adverse event' not be repeated.[161] And yet the Ombudsman reported in 2010 that the complaints process is still poorly signposted and mistakes are being repeated.[162] The Health Committee has made recommendations for a follow-up to complaints action plans, namely that the providers of NHS care and treatment be put under a contractual duty to report their complaints action plans and progress in implementing them to their commissioners and to the complainant. It is in the lack of follow-up that the learning system fails. Progress updates are then to be given to their local Healthwatch and Healthwatch England.[163] It is hoped that the reforms of 2009 will improve the sharing of information between complaints handlers and regulators. The Health Committee expressed support for the new two-stage process but was clear that there needed to be clear national standards for complaint handling and that one organisation (Healthwatch England) should be responsible for maintaining an overview of complaints handling in the NHS.[164]

F. History of the NHS Complaints Processes: A Curate's Egg?

As I stated at the beginning of this chapter, the Ombudsman's report of 2005[165] listed the essential elements for a new just system for complaints. These included accessibility; flexibility and transparency; the NHS being open and transparent about mistakes; offering effective complaint handling with links to clinical governance and finally a system offering just remedies. These just remedies would include provision for a full range of remedies for justified complaints, in particular; explanations, apologies, specific actions or treatment for the patient, changes to prevent recurrence and, where

[159] See Chapter 8 'NHS Redress Act 2006-A Lost Opportunity?' below.
[160] See Cave (n 6) at 146 for other options regarding duty of candour.
[161] See Chapter 2 'What Patients Seek from Redress' above.
[162] Cave (n 6) at 148.
[163] The Health and Social Care Bill 2011, cl 170, proposes to insert a new s 223A into the Local Government and Public Involvement in Health Act 2007.
[164] Cave (n 6) at 148 and Health Committee (n 16) 97.
[165] Abraham (n 13) ch 3 'Key Elements of a New System'.

appropriate, financial compensation. The NHS complaints system has a specific role to play in the panoply of redress for iatrogenic harm. Its remit is wider than that which is available through litigation. As we have seen, presently it is failing to deliver on the very tasks it was set up to address. I have discussed the difficulties of access which necessitate a patient first going through the PALS system and then, if required, ICAS. Open disclosure remains a hope rather than a statutory requirement. If there is no open disclosure there is no reason to offer explanations or apologies and at best, patients receive a letter from a Chief Executive of a Trust to the effect that 'we are sorry this happened to you'. So many years after the *Bristol Inquiry* there is as yet no credible system for learning from adverse events – the main priority for all patients embarking on the complaints system or litigation. In the present uncertain climate, Trusts are not in a position to promise future care. Apart from reimbursement of expenses, the complaints system does not offer significant compensation. This means that there is as yet no 'joined-up' redress offering explanation, apology, undertaking to repair and financial compensation. In the next chapter, I will discuss the NHS Redress Act 2006 which attempts to join up aspects of complaints and compensation to a certain limit.

Given that the right to complain about NHS services is written into the NHS Constitution, it is incumbent upon the NHS to have an effective and just complaints process. Many of the elements required are on the Government's agenda but have yet to be translated into action. In this chapter about the history of the NHS complaints processes, I first discussed the definition of medical error and the toll that complaints and litigation make on the medical profession. I then briefly reviewed the systems in place for regulation of the medical profession by the GMC; regulation of hospitals by the failing CQC, and investigative recourse for patients and their families namely, inquests and inquiries. I then considered the NHS complaints process past, present and future.[166] I think something valuable was lost by the eradication of the second stage of the complaints system. Arguably, the Independent Review Panels had their faults, but these were remediable. Complaints now go from local resolution, if unsuccessful, directly to the Ombudsman. The Ombudsman's office, which offers a very good service to those whose cases it investigates, is overstretched so that fewer cases can be reviewed. The Independent Panels were a way for patients to receive valuable independent clinical advice and to 'have their day in court'. The Health Committee's and the Ombudsman's reports give comprehensive recommendations on how to

[166] *Listening and Learning* (n 7) 2010-11 and Health Committee (n 16).

improve the present system in order to make it more responsive, accessible and effective. With the Government's intention to end legal aid for clinical negligence cases, settlements for the most seriously injured claimants could be eroded and access to justice for many will be undermined. The route for information, explanation and some just redress will increasingly fall upon the complaints process. The system at present is failing its constituents.

In the next two chapters I will discuss other avenues for just redress. First, I will consider the NHS Redress Act 2006[167] to see what remedies it was intended to offer and then finally I will consider what a comprehensive redress scheme for iatrogenic harm would offer, including apologies and financial redress for financial loss.[168]

[167] Chapter 8 'NHS Redress Act 2006 – A Lost Opportunity.
[168] Chapter 9 'Effective Redress'.

CHAPTER 8

THE NHS REDRESS ACT 2006 – A LOST OPPORTUNITY?

Redress: reparation of, satisfaction or compensation for, a wrong sustained or the loss resulting from this…Correction, amendment or reformation of something wrong…A means or way of redress, an act or arrangement whereby a person or thing is redressed.

The Shorter Oxford English Dictionary Third Edition

Redress: n. relief, remedy, compensation paid to one who has been injured.

Black's Law Dictionary Seventh Edition 1999

I. INTRODUCTION

The NHS Redress Act 2006[1] (hereinafter 'NHSRA' 2006) is the only statute entirely concerned with clinical negligence.[2] The statute represents an attempt to address the problems of clinical negligence litigation and is important because it potentially affects NHS hospital patients, with the intention of extending its operation to primary care. The underlying policy of the NHSRA 2006 was to provide a genuine alternative to litigation for low-value claims.[3] The Act, wholly concerned with the process of compensation, proposes a redress package where there has been clinical negligence in hospital. Applicants would need to show a 'qualifying liability in tort'.[4] The redress package *must* include: an offer of compensation; explanation; apology; and report of action to prevent similar occurrences.[5] The redress package *may* include care or treatment. The package can be accepted with waiver of the right to sue, or rejected. The redress scheme would be run by the National Health Service Litigation Authority (hereinafter NHSLA).[6] In addition, the Act was to provide a more integrated system of complaints and compensation.[7]

The NHS Redress Act 2006 received Royal Assent in November 2006 and was to have been implemented in April 2008.[8] Implementation was initially on hold pending further consultation and likely reform of the NHS complaints procedure.[9] Despite its successful passage through Parliament in 2006, the regulations to enact the NHS Redress Scheme have not been brought into effect in England.[10] In his review of legal costs,[11] Lord Justice Jackson has lent his support to implementation of the NHSRA 2006, stating that the scheme would be a sensible one which would facilitate the early and economic

[1] The NHS Redress Act will hereafter be called NHSRA 2006.
[2] M Powers, N Harris and A Barton, *Clinical Negligence*, 4th edn (Haywards Heath, Tottel Publishing, 2008), 'The NHS redress Act 2006'.
[3] AM Farrell and S Devaney, 'Making Amends or Making Things Worse? Clinical Negligence Reform and Patient Redress in England' (2007) 27 *Legal Studies* 4, 630-648. It is in the low cost claims that the costs are most disproportionate to the damages awarded.
[4] NHSRA 2006 (n 1), s 1(14).
[5] NHSRA 2006 (n 1), s 3(2).
[6] Powers et al (n 2).
[7] See A Simanowitz and S Burn, 'Clinical Disputes Forum: Litigation and Complaints – an Integrated System?' Consultation paper – (London, Clinical Disputes Forum, September 2001).
[8] M Brazier, and E Cave, *Medicine, Patients and The Law*, 5th edn (Harmondsworth, Penguin, 2011), 270.
[9] This is due to the widely held belief that the principles of the Act are closely related to the live consultation paper entitled *Making Experiences Count* regarding NHS Complaints Procedure Reform.
[10] House of Commons Health Committee, 'Complaints and Litigation' Sixth Report of Session 2010-12 Printed 22 June 2011.
[11] Right Honourable Lord Justice Jackson, *Review of Civil Litigation Costs; Final Report,* December 2009. (Hereinafter: Jackson Report).

resolution of lower value clinical negligence claims in respect of hospital treatment.[12] Lord Justice Jackson also stressed that the proposed scheme was one that would promote access to justice at proportionate cost.[13] As Emma Cave suggests, 'The Government may yet follow Lord Justice Jackson's advice and implement an NHS Redress Scheme. However, an alternative has been suggested: to implement a voluntary fast-track personal injury system for clinical negligence claims under the Road Traffic Act PI Scheme.'[14]

The NHSRA 2006 is an enabling Act and the detail of its operation is yet to be set out in secondary legislation. Notwithstanding, I will discuss the anticipated provisions, noting how these have changed between the original statement of intent[15] and the final Act.[16] I will highlight: the constraints on access to justice occasioned by the fact that it is a tort-based scheme; the issue of real and perceived independence if it is managed by the NHSLA; the failure to legislate for a duty of candour; the impossibility of ensuring NHS future treatment and the vexed question of the cost of the scheme. I will conclude this chapter by making a brief comparison with similar schemes in Wales and Scotland.

The lost opportunity regarding the Act is twofold: the *failure to draft regulations*, leaving in doubt whether the NHS Redress Scheme would be developed in England at all: *and the actual proposed provisions*, which 'failed by a large margin to live up to the aspirations for a radically different way of compensating patients'.[17] As regards the failure to enact the scheme, the previous Government[18] did not capitalise on the fact that there had been a unique consensus in all of the Parliamentary debates that an alternative to litigation had to be found. The NHSRA 2006 provided for by the legislation did at least offer some alternative, though modest, improvement. However flawed the scheme's process, there was more chance that lower value cases would have been

[12] 'Complaints and Litigation' (n 10), 45.
[13] Jackson Report (n 11).
[14] See E Cave, 'Redress in the NHS' (2011) 27 *Professional Negligence* 3, 138-157, 154 for details.
[15] CMO, *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (Crown Copyright, Department of Health, 2003) (hereinafter CMO, *Making Amends*).
[16] There has been extensive academic criticism of the envisioned Act. See [16] Brazier and Cave (n 8), 270; Farrell and Devaney (n 3); P Gooderham, 'Proposed Further Tort Reform After the NHS Redress Act: a Trojan Horse from *Making Amends'* (2007) 13 *The AvMA Medical & Legal Journal* 1, 25. Note that AvMA stands for Action against Medical Accidents; D Marsden and L Aderogba, 'The Impact of the NHS Bill on Clinical Negligence Litigation', (2007) 13 *Clinical Risk* 3, 96; P Walsh, 'Clinical Negligence Reforms Finally on the Way' (2005) 3 *Journal of Personal Injury Law* 267.
[17] P Walsh, 'Editorial' (2008) 14 *The AvMA Medical and Legal Journal* 4.
[18] Labour Government 1997-2010.

compensated more speedily and with less cost and stress.[19] Most significantly, for present purposes, it would have offered a preferable procedural route when compared with litigation, and could potentially combine compensation with apologies, explanations and system change.[20] As noted in the previous chapter,[21] all these features are necessary elements of just redress. As regards the limitations of the anticipated provisions, the present Government[22] has already acknowledged that the NHSRA 2006 'missed an opportunity to improve fundamentally the way clinical negligence claims are handled. It should have focused on improving the fact-finding phase prior to pursuit of a claim in order to facilitate faster resolution of claims, leaving it to the parties concerned, or ultimately the courts, to determine cases not resolved by fact-finding'.[23]

A. The Historical Context: The Dreams

In 2003, Sir Liam Donaldson, the then current Chief Medical Officer[24] (hereinafter 'CMO') published the *Making Amends* report which examined options for reform of the clinical negligence litigation system in England.[25] The political impetus for the report had its origins in earlier reports, including the Pearson Report,[26] 'Access to Justice', Lord Justice Woolf's wide-ranging investigation into the operation of the system of civil justice,[27] the National Audit Office's report Handling Clinical Negligence Claims in England[28] and, finally, the ground-breaking report: 'Learning from Bristol'.[29]

'Handling Clinical Negligence Claims in England' concluded that the current system was too complex, slow and costly.[30] The recommendation of 'The Bristol Report' was that the current system should be abolished entirely to be replaced by 'an alternative

[19] Walsh, 'Editorial' (n 17).
[20] Brazier and Cave (n 8), 270.
[21] Chapter 7 'History of the NHS Complaints Process: A Curates Egg?' above.
[22] Coalition Conservative and Liberal Democrat Government 2010-present.
[23] 'Complaints and Litigation' (n 10), 45.
[24] Hereafter 'CMO'.
[25] CMO, *Making Amends* (n 15).
[26] *The Royal Commission on Civil Liability and Compensation for Personal Injury* (1978) (The Pearson Commission), Cmnd 7054-1 (The Pearson Report).
[27] Woolf H, (1996) Access to Justice: Final Report to the Lord Chancellor on the Civil Justice System in England and Wales, (London, Lord Chancellor's Department, July 1996), 15.2.
[28] National Audit Office, *Handling Clinical Negligence Claims in England*, Report by the Comptroller and Auditor General, Session 2000-2001, HC 403, 3 May 2001 page 1.
[29] *Learning From Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-95*, Cmnd. 5207 (2001) (The Bristol Inquiry) Final report, Summary, paragraph 86, page 16; Recommendation 37, page 442. See also the prior reports of The Pearson Commission (n 26) and Lord Justice Woolf's report (n 27).
[30] National Audit Office (n 28).

administrative system' on the grounds that it fostered a 'culture of blame', which prevented the identification and analysis of errors.[31] Additionally, it is a salutary reminder that Lord Justice Woolf's investigation into the operation of the system of civil justice highlighted medical negligence as an area for special consideration on the grounds that it was in respect of these claims that civil justice was 'failing most conspicuously'. Lord Justice Woolf was also concerned to establish 'a climate of change marked by greater openness. He suggested that the GMC might explore ways of clarifying the responsibilities of the doctor in terms of candour,[32] and he also favoured the wider use of mediation schemes.

The CMO's report *Making Amends* contained a number of recommendations, one of the key ones being that a redress scheme should be established in relation to low-value claims in order to address long-standing patient concerns over the handling of adverse events arising out of medical treatment in the NHS.[33] In seeking to 'make amends' for harm suffered by patients as a result of adverse events in medical treatment within the NHS, the CMO rejected the introduction of a no-fault medical injury scheme.[34] Instead, the report recommended a redress scheme incorporating investigations of adverse events, provision of explanations and apologies, remedial treatment and rehabilitation where needed, and financial compensation where appropriate. These functions would be carried out in an efficient and non-adversarial manner reducing cost, delay and complexity from the scheme. The Government subsequently adopted the concept of a redress scheme, although its final form and substance differ significantly from that originally envisioned by the CMO.

In *Making Amends*, the CMO proposed reform of the existing negligence system, incorporating four main elements:

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[31] *Learning From Bristol* (n 29) Final report, summary, paragraph 86, 16; recommendation 37, 442. See also the prior reports of The Pearson Commission (n 26) and Lord Justice Woolf's report (n 27).

[32] See L Beecham 'GMC approves new Ethical Guidelines' (1998) 316 *British Medical Journal* 1556. The 'duty of candour' theme will be addressed below.

[33] C Vincent, M Young and A Phillips 'Why do people sue doctors? A Study of Patients and Relatives Taking Legal Action' (1994) 343 *The Lancet* 1609. An 'adverse event' is defined as 'an event or omission arising during clinical care and causing physical or psychological injury to a patient'. See Department of Health *An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS Chaired by the Chief Medical Officer* (London, TSO, 2000), xii.

[34] For a variety of reasons, predominantly those of cost. See JK Mason and GT Laurie, *Law and Medical Ethics* 8th edn (Oxford, Oxford University Press, 2011), ch 5, 127 and CMO, *Making Amends* (n 15), Chapter 6. Extensive discussion of a no-fault scheme is outwith the remit of this paper but on this subject see Mason and Laurie, just cited, ch 5, 127 and CMO, *Making Amends* (n 15), Appendix B.

(1) an investigation of the incident which is alleged to have caused harm and of the harm that has resulted.
(2) provision of an explanation to the patient and of the action proposed to prevent repetition.
(3) development and delivery of a package of care providing remedial treatment, therapy and arrangements for continuing care where needed.[35]
(4) payments for pain and suffering, out-of-pocket expenses and care or treatment which the NHS could provide.[36]

Making Amends is a thorough, aspirational report. However, as will be shown, the CMO's expansive concept of a redress scheme has been severely undermined by the Government's overriding political commitment to ensuring institutional control and cost containment in the operation of the scheme. I will now discuss the difficulties inherent in a tort-based scheme, including: the lack of independent legal advice; the lack of an independent body to run the redress scheme;[37] the failure to legislate for a duty of candour; the impossibility of ensuring NHS future treatment and note the vexed question of the cost of the scheme. And finally, I will note that there are four significant departures from the CMO's recommendations that have been lost between *Making Amends* and the final NHSRA 2006.[38]

II. ANTICIPATED PROVISIONS: THE REALITIES

A. Tort-Based Eligibility Scheme: Access to Justice

As and when the NHS Redress Act 2006 scheme is implemented, and assuming that such implementation would be as it has been conceived and approved by Parliament in 2008, the scheme will be tort-based and will primarily cover cases of clinical negligence.[39] Initially the scheme will apply only to cases involving liability in tort arising from hospital services provided as part of the NHS in England, whether provided for in England, in another part of the UK or abroad.[40] The scheme is not restricted to claims by patients; it may cover claims that could be brought following the death of a

[35] See Marsden and Aderogba (n 16), 96 and Walsh (n 16) for critique of remedial care packages.
[36] Ibid and CMO, *Making Amends* (n 15), page 16.
[37] 'While I welcome the Act, I nevertheless believe that an opportunity was missed to make the fact-finding stage of investigation of disputes truly independent. The danger is that local NHS trusts will act as judge and jury in their own cause. I question whether this will ensure a thorough investigation of the facts and command the confidence of patients.' Powers et al (n 2).
[38] For detailed analysis of the NHS Redress Act 2006 see Farrell and Devaney (n 3) and Brazier and Cave (n 8), 270.
[39] NHSRA 2006 (n 1), s 1.
[40] Ibid.

patient by virtue of the Law Reform (Miscellaneous Provisions) Act 1934 or claims brought by the dependants of a deceased patient under the Fatal Accidents Act 1976.[41] The scheme would exist in parallel with the common law.

I have argued that the moral basis for redress for iatrogenic harm rests on the concept of corrective justice. In order to 'restore patients to as near as possible to the position they would have been in but for the negligent act which caused them to suffer harm,'[42] the parameters of a just redress scheme within the NHS in England must include, *inter alia*: facilitating access to justice; access to justice to be generously defined to include expansive eligibility criteria and the capacity to pursue redress against all relevant parties. The problem of tort-based eligibility criteria is that, because the Act confines redress to cases of personal injury arising from breach of duty, the need to prove both breach and causation remains intact. Both pose considerable difficulties for claimants.[43] In *Making Amends*, the CMO had suggested that a 'lower qualifying threshold' might be appropriate but suggestions for alternative approaches to determining eligibility under the scheme which are not as onerous for patients to establish have not been followed through by the Government. The patients' charity, Action against Medical Accidents[44] suggested that a further alternative – the 'avoidability test' – should be used to determine eligibility for financial compensation under the redress scheme. Under this test an adverse event would be compensable 'except where it is the result of an unavoidable complication regardless of treatment or non-treatment'.[45] I argue that because the test for eligibility under the scheme is identical to that used by the courts, all of the difficulties claimants face in establishing liability in negligence will be reproduced under the NHS Redress Scheme. As I have not advocated replacing tort criteria with a no-fault system, I am not arguing for a more expansive eligibility route to the redress scheme. However, there is a problem about equality of arms for would-be claimants as concerns proving eligibility for the scheme.

In the current clinical negligence system, tort law principles are applied where patients have the benefit of independence in terms of legal representation, investigation of the facts and adjudication. This level of independence is designed to ensure procedural and

[41] NHSRA 2006 (n 1), s 1 (4) (a).
[42] *Lim Poh Choo v Camden & Islington Area Health Authority* [1980] AC 174 at 187 per Lord Scarman.
[43] See Farrell and Devaney (n 3); E Jackson, *Medical Law* 2nd edn (Oxford, Oxford University Press, 2010), 163 and Part II Medical Negligence Litigation, above.
[44] Action against Medical Accidents is hereinafter referred to as 'AvMA'.
[45] Jackson (n 43), 163.

substantive fairness between the parties and is of particular importance to patients, given the imbalance between the parties.[46] It is mooted that in the details of the Act[47] patients will not have access to independent legal and expert advice at crucial points. Legal assistance would only be provided for advice relating to the offer and any settlement agreement,[48] and the provision of the services of jointly instructed medical experts.[49] This would leave patients unable to have a clear idea of their eligibility under the redress scheme and the strength of their claim.[50] In the present climate, with legal aid about to be removed for clinical negligence actions, access to this other significant route to just redress will in fact be curtailed. This is unacceptable. I now turn to the question of the perceived and real independence of the scheme.

B. Independence: Perception and Reality

One of the most contentious aspects of the legislation is the perceived and actual independence of the scheme. The Redress Act 2006 stipulates that a specified Special Health Authority must be provided to have such functions in connection with the scheme as the Secretary of State thinks fit. The appointed authority will deal with questions of liability and quantum and will oversee the scheme generally and monitor consistency. Although the Act does not specify who the Scheme Authority will be, the Department of Health has stated in numerous papers that the National Health Service Litigation Authority is the intended authority.[51]

The NHSLA currently handles all clinical negligence claims made against the NHS and is presently the body which determines whether to admit or deny liability for an incident on behalf of the NHS. This body has thus far played a very one-sided role in clinical negligence litigation. There is obviously a very real concern that the NHSLA will lack independence, either perceived or actual. This could undermine public confidence in the

[46] M Galanter, 'Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change' (1974) 9 *Law and Society Review* 1, 95-160.
[47] NHSRA 2006 (n 1), s 8.
[48] NHSRA 2006, (n 1), s 8 (2).
[49] NHSRA 2006, (n 1), s 8 (1) (b). See Aldous, G (ed) (2011) *Clinical Negligence Claims: A Practical Guide* 2nd edition (London, Chambers of G Aldous QC, 9 Gough Square), 50 for details.
[50] This is due to the curtailment of access to independent medico-legal advice. Farrell and Devaney (n 3), 635 and Brazier and Cave (n 8), 270...'it seems unlikely that the applicant will receive free and independent legal advice as to whether a complaint, an application for redress under the scheme or a clinical negligence claim is suitable. Additionally, would lawyers and doctors be willing to work for the flat fee to be offered?
[51] Aldous (n 49), 48.

scheme or at worst lead to insufficient offers of compensation being offered or failure to accept liability.[52]

Those opposed to the appointment of the NHSLA as Scheme Authority argued that it was inappropriate for the NHSLA to perform what is, in effect, a judicial function: assessing and valuing claims deemed eligible for the scheme in line with relevant tort law principles.[53] Moreover, such appointment facilitates a situation whereby the NHS is able to act as 'judge and jury' of its own mistakes.[54] The appointment of the NHSLA as Scheme Authority represents a clear conflict of interest for the body under the current system and may prove fatal to any trust patients may have in the scheme. The inequality of arms as regards legal representation at the eligibility/liability stage of the scheme is a glaring injustice to would-be claimants. I think that this clear case of conflict of interest causes the scheme to be severely compromised.[55]

1. Appeals

A just redress scheme should have provision for an independent appeals mechanism in cases where the initial determination is disputed. This element is, however, missing from the remit of the NHS Redress Scheme. Patients, who are dissatisfied with the outcome of their claim, have two options under the scheme: first, to accept the decision reluctantly or, second, to pursue the case, again under the existing litigation system.[56] Alternatively, a dissatisfied patient may complain.[57]

C. Redress

Redress under the scheme will comprise of a number of elements, namely: financial compensation where appropriate, explanations and apologies (which it is envisaged will cover explanations of how the harm or loss came about) and, in appropriate cases,

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[52] Ibid.
[53] E Howe, NHS Redress Bill, Grand Committee, House of Lords, 21 November 2005, cols GC327 and 360.
[54] This is what the Government's comments supporting improved fact-finding rather than adjudication refer to. See Introduction, above.
[55] The second stage of the 1996 Complaints Procedure, the Independent Review Panel, was eliminated in major part because of a perceived conflict of interest for the 'gate-keepers' the convenors who decided whether or not they were held. Chapter 7 'History of the NHS Complaints Process- A Curate's Egg?' above.
[56] Farrell and Devaney (n 3), 638.
[57] NHSRA 2006 (n 1) s 14; Aldous (n 49), 51.

offers, including contracts for future remedial care, may be made as well as financial compensation.[58]

1. Financial Compensation

The scheme will be targeted at lower value claims of a straightforward nature, which are currently dealt with by way of litigation. The threshold amount is £20,000.[59] These are the types of claim where the costs of pursuit of the claim by the traditional route outstrip the amount of compensation ultimately recovered. The mechanism for assessment of that compensation, by way of general damages and special damages, should be in line with the general law on damages, so that offers of financial compensation will be broadly equivalent to the level of compensation that would be provided in a successful claim before a court. In the event that an offer of redress is accepted by the patient, he will be required to enter into a settlement agreement which will include a 'waiver of the right to bring civil proceedings in respect of the liability to which the settlement relates'.[60] The Clinical Disputes Forum[61] proposed that, if a claimant accepted compensation awarded by the tribunal (redress scheme) he should waive the right to seek further compensation in the courts. However, the Forum foresaw that this clause could be in breach of the European Convention on Human Rights and the Human Rights Act 1998, especially Article 6(1) – the right to a fair trial before an independent and impartial tribunal.[62] Although not provided for by the Redress Act, it is envisioned by the Department of Health that all offers of settlement under the scheme would be made without prejudice and will not be capable of being considered an admission of liability in a later court case.[63]

[58] D Dow and J Lill, *Personal Injury and Clinical Negligence Litigation* (Guildford, College of Law Publishing, 2007), 140.
[59] P Balen, *Clinical Negligence* (Bristol, Jordan Publishing Limited, 2008), 46.
[60] NHSRA 2006 (n 1), s 3(5) (b). Any offers of redress by the scheme authority will be made on a 'without prejudice' basis, as neither offers nor settlements are to be regarded as an admission of liability for the purposes of subsequent litigation. Department of Health *NHS Redress: Statement of Policy* (Crown Copyright, 14 November 2005), 4. See NHSRA 2006 (n 1), s 6(5) and Farrell and Devaney, (n 3), 638.
[61] Simanowitz and Burn (n 7).
[62] Ibid. '…The waiver could amount to a deprivation of his right to a fair hearing in the courts unless he took legal advice in advance and opted out of the court process on a truly informed basis.'
[63] Aldous (n 49), 49.

2. Explanations

The Act provides for explanations to be given concerning harm suffered in incidents giving rise to applications under the scheme.[64] The need for a full and adequate explanation, as well as an apology, has been described as a high priority for patients in these circumstances.[65] A reading of the Act does not reveal what is meant by 'explanations', or in what circumstances explanations will be excluded from the scheme.[66] For present purposes it is sufficient to highlight the need for meaningful explanations and apologies in the context of clinical negligence disputes.[67] The starting point for full explanations rests with the obligation of a duty of candour; however the Act does not impose one. At the time of writing, the Government has defeated a proposed amendment to the Health and Social Care Bill 2011 which would have required the creation of a statutory 'duty of candour' with patients when things go wrong in healthcare and cause harm.[68] Instead, the Government will rely upon contractual duty of candour clauses between NHS Commissioning Boards and providers. This should be extended to contractual duty of candour to their populations as well.[69]

3. Future Remedial Care

In appropriate cases, contracts for future remedial care may be made in addition to any offer of financial compensation. This aspect of the scheme is a particularly contentious issue amongst those advising the victims of clinical negligence.[70] There are long-standing concerns over whether the NHS is capable of providing rehabilitative services of the appropriate quality and suitably tailored to the needs of individual patients, given that this area has long suffered from a chronic lack of funding as well as a lack of

[64] NHSRA 2006 (n 1), s 10.
[65] See M Bismark and EA Dauer, 'Motivations for Medico-Legal Action – Lessons from New Zealand' (2006) 27 *The Journal of Legal Medicine* 55.
[66] See Farrell and Devaney (n 3), 639.
[67] 'Apologies and Civil Liability in England, Wales and Scotland: The View from Elsewhere' (2007) *University of New South Wales Faculty of Law Research Series* Paper 61 (online at bepress Legal Repository) and P Vines, 'The Power of Apology: Mercy, Forgiveness Or Corrective Justice In The Civil Liability Arena?' (2007) 1 *Public Space: The Journal of Law and Social Justice* 1, 1-50.
[68] Press Release AvMA 14.02.12.
[69] Note Chapter 7 History of Complaints Process: A Curate's Egg? and 'Complaints and Litigation' (n 10), Conclusions and Recommendations (Para 82).
[70] Marsden and Aderogba (n 16), 97 and Farrell and Devaney, (n 3), 641.

appropriate resourcing in terms of equipment and personnel.[71] There is a question as to whether the claimant would wish to receive remedial treatment from the perpetrator of the harm. The practicalities become an ethical dilemma. Should this group of patients receive preferential treatment by being moved up waiting lists to the disadvantage of others? A final concern for the claimant: under the current system, claimants who are successful in clinical negligence claims are able to claim the cost of care and treatment in the private sector, including rehabilitation services, regardless of whether it could be provided by the NHS.[72] This pre-existing entitlement may have been removed under the Act in relation to claims within the remit of the scheme. This needs clarification prior to the implementation of the Act.

D. Lost in Transit

There are several significant departures from the CMO's recommendations in *Making Amends*. First, the CMO recommended a separate, no-fault *NHS Redress Scheme for Severely Neurologically Impaired Babies,*[73] where it could be shown that the injury was birth-related. Currently, only around one third of cerebral palsy births result in a claim in clinical negligence. Of these, only one third receive damages, averaging since 1995 at around £650,000. The claims are costly in terms of both the emotional effects on parents and health professionals, and the financial effects on the NHS. The CMO was impressed by no-fault schemes for birth-related neurological injuries run in Virginia and Florida, USA. Although the Government has not ruled out such a scheme, it forms no part of the NHS Redress Act 2006.[74] Second, the CMO recommended a 'duty of candour' to encourage openness in the reporting of adverse events.[75] As noted, the Act does not include a duty of candour. The third major departure from *Making Amends* was the CMO's thirteenth recommendation that 'documents and information collected for identifying adverse events should be protected from disclosure at court'. The aim was to limit disincentives to reporting of adverse events. This too was rejected by the

[71] Department of Health *National Service Framework for Children, Young People and Maternity Services: Disabled Children and Young people and those with Complex Health Needs* (Crown Copyright, 2004).
[72] S 2(4) of the Law Reform (Personal Injuries) Act 1948.
[73] CMO, *Making Amends* (n 15), recommendation 2.
[74] Brazier and Cave (n 8), 270.
[75] CMO, *Making Amends* (n 15), recommendation 12. One can look to New Zealand, where patients are compensated without proving fault through the Accident Compensation Corporation, doctors have a legal duty of candour and adverse events are usually admitted. P Davis *et al,* 'Acknowledgement of "No-Fault" Medical Injury: Review of Patients' Hospital Records in New Zealand', (2003) 326 *British Medical Journal* 79.

Government. The balance between the public interest in encouraging reporting and the individual interest in access to information was, it felt, not properly reflected in a protection from disclosure. The NHS is patient-focused; such defensiveness was contrary to public policy.[76]

The final major departure from *Making Amends* has been, as noted above, the lack of provision for an independent body to oversee the redress scheme. Significant measures proposed in *Making Amends* designed to increase openness and reduce the blame culture have been excluded. What started as an ambitious and compassionate next step in the Government's oft-stated commitment to improve the handling of complaints within the NHS[77] has, by some mysterious alchemy, turned into a redress scheme 'designed primarily to suit the institutional and financial preferences of the NHS, that will not operate as a just redress scheme sensitive to patients' concerns where they have suffered harm as a result of (negligent) adverse events in medical treatment'.[78]

E. Cost

The final biggest drawback of the scheme is its cost. The Act did not satisfy economists because although it would reduce delay, it would be costly to set up and would most likely bring in new claims.[79] It was estimated that the scheme would cost £42 million per year.[80] There are at present two proposals for fast-track low-value clinical negligence schemes: Lord Justice Jackson's proposal that the abandoned NHS Redress Act 2006 be resurrected[81] and Lord Young's proposal that the Road Traffic Act fast-track scheme be extended to clinical negligence claims.[82] Whether the latter can be adapted for the more complicated issues in clinical negligence claims is an open question. Neither satisfies the elements for a 'just redress' set down by the CMO, but I

[76] Ibid.
[77] See *An Organisation with a Memory* (n 33) and CMO, *Making Amends* (n 15), both excellent reports by the CMO and MA Mansell, 'NHS Redress-Progress and Problems', (2005) 73 *Medico-Legal Journal* (2005) 4, 121.
[78] See Farrell and Devaney, (n 3) and academic articles cited above.
[79] Brazier and Cave (n 8), 270.
[80] P Fenn, A Gray and N Rickman, 'The Economies of Clinical Negligence Reform in England' (2004), 114 *The Economic Journal* 262 at 289, C.
[81] Jackson Report (n 11), Chapter 23, paras 7 and 8.
[82] HM Government, Lord Young, Common Sense, Common Safety: A report by Lord Young of Graffham to the Prime Minister following a Whitehall‑wide review of the operation of health and safety laws and the growth of the compensation culture (October, 2010), 23 See Cave (n 14), for fuller picture of both schemes and what they might offer.

would welcome an initiative that would show that the financial and other aspects of redress can be addressed in one scheme.

III. OVER THE RAINBOW: WALES and SCOTLAND

Whereas the political will to enact the NHSRA 2006 appears to be missing in England, it is of note that the Welsh Assembly has forged ahead with a redress scheme.[83] The NHS (Concerns, Complaints and Redress Arrangement) (Wales) Regulations 2011 form part of the Welsh Assembly Government's 'Putting Things Right' project and is designed to align complaints and redress. Most of the regulations came into force on 1 April 2011 and the rest came into force in October 2011. Wales has been operating a successful[84] optional Speedy Resolution Scheme for low-value claims[85] since 2005. However, The NHS Redress (Wales) Measure 2008 is designed to align complaints and redress. This legislation introduces a single portal for 'concerns' which include 'an expression of dissatisfaction, a complaint, a claim for compensation and any issue arising from a patient safety incident.'[86] When a concern is raised, a responsible body would have thirty days to investigate the issue and provide a written response. This might incorporate an apology or action taken, and include a right to take the case to the NHS Ombudsman or request further information. Under regulation 21 there is a requirement on the responsible body to consider whether there is a 'qualifying liability in tort', in which the redress process would be activated. Albeit that the scheme shares a number of the potential flaws with the proposed English scheme discussed above, it is a real attempt to bring together a fragmented system of redress. The scheme represents a positive attempt to offer a just and unified approach to redress and is a welcome initiative.[87] Initially, the Welsh Redress Scheme and the Speedy Resolution Scheme, both for lower value clinical negligence claims in Wales, will be operating side by side.

In Scotland, the language of patients' rights has been to the fore. The Patients Rights (Scotland) Act 2011 sets out the basic rights that NHS Scotland should uphold for patents,[88] while its schedule sets out healthcare principles.[89]

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[83] NHSRA 2006 (n 1) s 17 gave the National Assembly for Wales the power to introduce an NHS redress scheme. Brazier and Cave (n 8), 271.
[84] M Rosser, 'The Changing Face of Clinical Negligence in Wales' (2010) 3 *Journal of Personal Injury Law* 162 at 169 and Brazier and Cave (n 8), 271.
[85] Low value claims are claims between £5,000 and £15,000.
[86] Brazier and Cave (n 8), 271.
[87] Ibid.
[88] The Patients Rights (Scotland) Act 2011, s 3.

In these times of financial constraints it is understandable, though regrettable, that the Government's commitment to redress for iatrogenic harm has been eclipsed by more pressing NHS reforms. With the pending withdrawal of legal aid from clinical negligence suits, other avenues where 'joined-up' redress for the variety of losses iatrogenic harm occasions must be sought. The Welsh and Scottish attempts to address this issue will be worth watching.

IV. CONCLUSION: THE NHS REDRESS ACT 2006

The analysis of the redress scheme offered above has been hampered by the lack of clarity offered by the enabling Act without the secondary legislation. When the Government embarked upon the process of clinical negligence reform, there was widespread stakeholder and political support for the concept of a redress scheme in relation to low-value claims.[90] This support has diminished over time as the parameters of the scheme became clearer. I have discussed the limitation on access to justice when eligibility for the scheme remains tort-based. The restriction on independent legal and medical advice at the liability stage is problematic. There are serious questions of real and perceived independence if the scheme is run by the NHSLA. The failure to legislate for a duty of candour shows a lack of commitment by the Government to this issue. I am in agreement with the Health Committee that, pragmatically, a contractual duty might work better and am not sure that legislation would change the culture of lack of candour. A more serious problem is the inability to ensure NHS future treatment and the vexed question of the cost of the scheme. I have noted that the way forward may be a resurrection of the NHSRA 2006 or a fast-track system. The lost opportunity was the failure to enact the Act at the time when there was a political will for it to succeed. It was flawed but offered a chance for 'joined-up' redress.

I turn now to the concluding chapter where I will consider the necessary elements for effective redress for iatrogenic harm. I will be discussing effective and just redress, including financial compensation for pecuniary loss, but I will concentrate on redress for non-pecuniary loss with an emphasis on the role of apologies in their broadest sense.

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[89] Further detail is outwith the remit of the thesis.
[90] Simanowitz and Burn, (n 7).

CHAPTER 9

EFFECTIVE REDRESS AND THE ROLE OF APOLOGIES

> Apologies have many roles: the psychological, sociological, philosophical and anthropological literature shows that apologies can have a healing and re-balancing function for both victim and relationship, and often for the offender as well. They may also have a moral, meaning-creating and educative function of reinforcing the sense of the norms of right, wrong and responsibility in the community and between victim and offender, and possibly an underlying function of reducing aggression which has biological/evolutionary roots. Most of these functions require an apology to acknowledge fault rather than merely to express regret if they are to be effective – that is, in order to elicit the next stage in a reconciliation process.[1]

[1] P Vines, 'Apologising for Personal Injury: the Effectiveness of New Legislation in Medical Malpractice Litigation' (2010) Lecture at University of New South Wales. Lecture Notes from the Author, May 2012.

I. INTRODUCTION

This concluding chapter is concerned with what an effective redress system would contain. I have already addressed this issue when considering the complaints procedure,[2] and in this chapter I look more broadly at the problem of redress for the more intangible aspects, focusing on redress for non-pecuniary loss. The chapter starts, in Section II, with a review of the central problems in the current system(s). I then turn, in Section III, to consider what an effective redress system would look like. In this regard, because knowledge and acknowledgement of the adverse event is crucial both to litigation and complaints, I have chosen to focus on the role of apologies in facilitating effective redress. I conclude that without a system for full apologies, as defined in the chapter, there cannot be effective redress. However, to achieve the aims of corrective justice, redress would have to include forms of reparation and compensation. The nearest model for effective redress for iatrogenic harm in the UK is in its embryonic form in Wales[3] and will be watched attentively.

II. TAKING STOCK: REDRESS FOR IATROGENIC HARM

In this, my concluding chapter, I will discuss the requirements for an effective redress scheme for iatrogenic harm. I begin, however, with a review of my arguments regarding redress and briefly summarise the deficiencies of the existing legal and complaints systems.

A. Redress: The Moral Imperative
Claimants and Defendants

I have premised the obligation for victims of iatrogenic harm to be compensated upon corrective justice principles,[4] constrained by notions of distributive justice[5] when it comes to paying damages from an overstretched NHS budget.[6] Corrective justice theory

[2] Chapter 7 History of NHS Complaints Processes – 'A Curate's Egg?' Introduction section and Ann Abraham, The Health Service Ombudsman for England, 'Making Things Better? A Report on Reform of the NHS Complaints Procedure in England' HC 413 (London, The Stationery Office, 9 March 2005) Chapter 3 'Key Elements of a New System'.
[3] Chapter 8 'The Redress Act 2006 - A Lost Opportunity' Section III above.
[4] Chapter 1 'Corrective Justice and Entitlement to Redress within the NHS' above.
[5] See *McFarlane v Tayside Health Board* [2000] 2 AC 59.
[6] Note: all my arguments are confined to issues in the context of the NHS, a universal, welfare health system. 'The real cost of clinical negligence is much greater than the £16 billion paid out by the NHSLA' in D Brahams, 'The Rise of Dodgy Insurance Claims and the Huge Price of Negligent Medical Treatment

focuses strongly on the connection between law and morality by arguing that there is a specific obligation against the individual who causes harm to correct that harm in some way.[7] This is an obligation-based ethical position and is not negated by the fact that the patient has been harmed within the confines of the NHS. There is no reason why the NHS, a welfare-model universal service, should not be held to account for adverse events, and the best way of reducing claims is to improve the standard of medical care and treatment that is provided by doctors and the NHS generally.[8] I have opted for a tort model of redress[9] which seeks to *restore the patient to his pre-tortious state*. This presents a serious challenge when the damage is iatrogenic harm. The aim then becomes to restore the patient to the best approximation of his pre-injured state, which may in fact have been a health-compromised one. Therefore, in the discussion of redress, one is thinking of a compensatory system which can at best only provide partial relief. Within the confines of actions for clinical negligence, I do not see the tort system operating as an effective deterrence because *human error is by definition unintentional, and therefore not easily deterred*.[10] In addition, I argue that while larger awards are being paid out – the result of higher annual payments to claimants who are living longer because of medical developments[11] – there is no evidence of a *compensation culture.* The concept of a compensation culture is, in fact, one of 'perception rather than reality.'[12] In fact, such evidence as there is strongly suggests that the actual numbers of claims has been falling over the last few years.[13]

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to the National Health Service" (2012) 80 *Medico-Legal Journal* 1 and see National Health Service Litigation Authority (2011) *Reports and Accounts*.

[7] E Weinrib, *The Idea of Private Law* (Cambridge, Mass, Harvard University Press, 1995), 57. See Vines, P, 'Apologising to Avoid Liability: Cynical Civility or Practical Morality?' (2005) 27 *Sydney Law Review* 5, 483-505, 502.

[8] Brahams (n 6) 2.

[9] "[t]ort law is a set of rules and principles of personal responsibility...Peter Cane, *The Anatomy of Tort Law*, (Oxford, Hart Publishing, 1997), 15.

[10] Merry, A, and McCall Smith, A, *Errors, Medicine and the Law* (Cambridge, Cambridge University Press, 2001), 2. Because negligence is not intentional is it morally as well as legally wrong? It is regarded as morally culpable in some situations; and lies between the two situations of intention to create harm and pure coincidental accident. Vines, P, 'The Power of Apology: Mercy, Forgiveness or Corrective Justice in the Civil Liability Arena?' (2007) 1 *Public Space: The Journal of Law and Social Justice* 1, 1-50, 13.

[11] Brahams (n 6), 2.

[12] HM Government, Lord Young, 'Common Sense, Common Safety: A report by Lord Young of Graffham to the Prime Minister following a Whitehall‑wide review of the operation of health and safety laws and the growth of the compensation culture' (October, 2010), 19. For critique of the *Young Report* see J Goudkamp, 'The Young Report: an Australian Perspective on the latest Response to Britain's 'Compensation Culture' (2012) 1 *Professional Negligence* 4-26.

[13] C Lewis and A Buchan, *Lewis and Buchan: Clinical Negligence*, 7th edn (Haywards Heath, Bloomsbury Professional, 2012), 4. Due in part to decline in the availability of legal aid.

The main conceptual difficulty in a fault-based liability system of corrective justice is that the defendant tortfeasor does not pay the damages himself.[14] The system depends upon the availability of liability insurance. Nonetheless, the fact that the tortfeasor has taken out third-party insurance can be seen as a willingness on his part to make amends should the situation arise. In my discussion of apologies below, the significance of the negligent doctor personally relating to the victim of iatrogenic harm has great currency. Rehearsal of a no-fault system is outwith the remit of the thesis, but I note that a no-fault system would fail to address patients' desires for apologies and explanations, and would not necessarily promote learning from mistakes.[15] In basing my argument on corrective justice principles, I would reject no-fault schemes on the basis that they neglect the necessary moral recognition of responsibility. However, this is a moot point at present as it is unlikely that a no-fault scheme would be introduced in England as the Chief Medical Officer estimated that a no-fault scheme would be unaffordable for the NHS.[16]

I now turn to the question of what patients seek from redress and how far any scheme can realistically meet their needs.[17] The starting point is that patients are motivated to take medico-legal action in the desire for: *restoration,* including financial compensation or some other intervention to make the patient whole again; *correction,* such as a system change or *competence review* to protect future patients; *communication,* which may include an explanation, expression of responsibility, or apology; and *sanction,* including professional discipline or some other form of punitive action.[18] I have discussed what patients seek in my earlier chapter,[19] but here I want to consider the extent to which these needs can be met.

Patients suffering from iatrogenic harm within the context of the NHS are both patients with rights to safe healthcare and citizens with responsibilities to the whole

[14] As P Vines, I assume that the paradigm of negligence concerns a dyadic interaction between two private individuals. That the NHS may be a party doesn't negate the theoretical point. Vines (n 10), 15.
[15] Jackson, E, *Medical Law* 2nd edn (Oxford, Oxford University Press, 2010), 161.
[16] Chief Medical Officer, *Making Amends: A Consultation Paper Setting out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (Crown Copyright, Department of Health, 2003) at 112 as discussed in Jackson (n 15), 161.
[17] Chapter 2 'Iatrogenic Harm: What Patients Seek from Redress' above.
[18] M Bismark, E Dauer, 'Motivations for Medico-Legal Action – Lessons from New Zealand' (2006) 27 *The Journal of Legal Medicine* 55.
[19] Chapter 2 'Iatrogenic Harm: What Patients Seek from Redress' above.

community.[20] Starting with the notion of *restoration*, as noted above, in clinical negligence actions this can at best be partial. The need for *financial compensation for pecuniary loss* such as loss of earnings and future care does not present a theoretical challenge and pecuniary loss contingent upon negligence should be paid in full. The ethical challenge lies in the tension between what is owed to the harmed patient related to negligent past care and what is then left for the care of future patients. I address this problem of distributive justice by arguing that *non-pecuniary loss* should be compensated by means other than money.[21] My reasoning is both pragmatic and philosophical: pragmatic because of the financial constraints on the NHS budget, but more importantly, philosophical, because these losses, being non-commodifiable, cannot in any meaningful way be assuaged by money.

Medical negligence litigation for damages for pecuniary loss is conceptually simpler but in practice difficult to achieve.[22] Nevertheless, it is a like-for-like, calculation. Although studies of patients' motivations for medico-legal action often note that financial compensation is not necessarily the prime motivator, where there are major financial losses, undoubtedly financial compensation becomes important.[23]

In this chapter, I concentrate on extending redress for intangible non-pecuniary loss. In particular, I consider the role that *full apologies* might play in facilitating resolution of this aspect of clinical negligence disputes. I have modest expectations of what apologies can achieve. I do not see apologies as a panacea in addressing non-pecuniary loss. Unfortunately, patients put a high premium on apologies and have what I consider unrealistic expectations of how emotionally remedial an apology would be.[24] Apologies might well not bring *closure*; the iatrogenic harm, bereavement and longing may persist. Nonetheless, *full apologies* can offer explanations, without which patients cannot make informed decisions about whether or not, and which avenues, to pursue for redress. Apologies can offer acknowledgement that an adverse event has occurred and that the

[20] M Brazier, 'Do No Harm–Do Patients Have Responsibilities Too?' (2006) 65 *Cambridge Law Journal* 397. Actions taken to satisfy a retributive instinct are unhelpful. I have sat on Independent Review Panels where nothing short of annihilation of the doctor would suffice. S Ehrenzweig, 'A Psychoanalysis of Negligence' (1953) 40 *Northwestern University Law Review* 855.

[21] I have allowed awards for bereavement under the Fatal Accidents Act 1976 because of their historic symbolic value.

[22] Part II Medical Negligence Litigation: Chapter 3 Funding Litigation; Chapters 4 and 5 Proving Liability; Chapter 6 Damages, above.

[23] Chapter 2 'Iatrogenic Harm: What Patients Seek from Redress' above.

[24] In England, to date, there have not been programmes offering full apologies so the question of how illusory the relief might be is a speculative one.

tortfeasor takes responsibility for the injury. They can offer space to consider remedial opportunities. I will discuss the Australian,[25] Canadian[26] and American[27] literature regarding disclosure and the relationship between apologies and litigation but for present purposes I am not championing apologies as a means of reducing the NHS litigation bill. Prior to considering apologies, I will briefly review the central problems in the current systems offering redress to iatrogenically harmed patients.

B. Litigation and Complaints
Claimant or Complainant?

1. An Integrated System?

As long ago as 1997, the Clinical Disputes Forum was set up by Lord Woolf to consider the interface between litigation and complaints, in the hope of integrating the systems dealing with clinical negligence cases.[28] At present, 'despite progress in improving various aspects of NHS redress, the clinical negligence system litigation perpetuates injustice for both patients and healthcare professionals.' [29] The key requirement, 'a joined-up system,'[30] is still missing. The Redress Act 2006,[31] still *a lost opportunity* would, despite its failings,[32] have been a united mechanism by which different forms of redress might have been delivered. It may be that the recommendations of the *Young Report*[33] to extend to medical negligence claims the simplified procedure applicable to road traffic accidents[34] will be pursued by the present Government. Whether the more complex nature of clinical negligence cases can successfully be accommodated in this manner is open to question.[35] Presently, we might look to Wales,[36] which has been

[25] P Vines, 'Apologies and Civil Liability in England, Wales and Scotland: The View from Elsewhere' (2008) 12 *Edinburgh Law Review* 2, 200. and Vines (n 1).
[26] Canadian Patient Safety Institute, *Canadian Disclosure Guidelines: Being Open with Patients and Families* 2011 at www.patientssafetyinstitute.ca and W Levinson and T Gallagher, 'Disclosing Medical Errors to Patients: A Status Report in 2007' (2007) 177 *Canadian medical Association Journal* 3, 265.
[27] GH Teninbaum, 'How Medical Apology Programs Harm Patients' (2011) Suffolk University Law School Legal *Studies Research Papers Series* Research Papers 11-30 1-41.
[28] S Dewar, B Finlayson and S Williams, *Building Effective Interfaces: Systems for Complaints, Litigation, Discipline, Regulation and Clinical Governance* (London, Clinical Disputes Forum, 2003). http://www.clinical-disputes-forum.org.uk/files/publications/ProjectBMainText.pdf
[29] E Cave, 'Redress in the NHS' (2011) 27 *Professional Negligence* 3, 138-157, 139.
[30] Ibid.
[31] Chapter 8 NHS Redress Act 2006 –A Lost Opportunity
[32] Ibid.
[33] Young (n 12).
[34] With an increased ceiling of £50,000.
[35] Young, (n 12), 25. For critique of the *Young Report* see Goudkamp (n 12), 23.

operating a successful optional Speedy Resolution Scheme for low-value claims[37] since 2005 and The NHS Redress (Wales) Measure 2008 which is designed to align complaints and redress.'[38] Initially, the Welsh Redress Scheme and the Speedy Resolution Scheme, both for lower value clinical negligence claims in Wales, will be operating side by side and it will be instructive to see how they work.

2. Medical Negligence Litigation: Access to Justice?

If a claimant is seeking damages for *pecuniary loss* the only avenue to pursue is an action for clinical negligence. The first stumbling block in the way of access to justice is the curtailment of the availability of legal aid for funding a suit.[39] It is replaced with no-win-no-fee agreements.[40] Part 2 of the Legal Aid, Sentencing and Punishment of Offenders Act 2010-2012 takes forward Lord Justice Jackson's proposals in his Civil Litigation Costs Review.[41]

Restriction of funding is a particular disadvantage in clinical negligence cases because these cases can be very expensive to investigate and pursue in the process of finding out what and why things went wrong and whether negligent treatment was the cause of any injury claimed and the extent of the injury.[42] As discussed in the chapter on funding,[43] once these cases are primarily funded by no-win-no-fee provision, only obviously winnable cases will be considered.

The legal route to redress through an adversarial system is quintessentially about obtaining damages.[44] It is fraught with particular difficulties and has a lower success rate than general personal injury claims. The claimant has great challenges in proving

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[36] M Rosser, 'The Changing Face of Clinical Negligence in Wales' (2010) 3 *Journal of Personal Injury Law* 162 at 169 and M Brazier, E, and Cave, *Medicine, Patients and The Law*, 5th edn Penguin, 2011) at 271.
[37] Between £5,000 and £15,000.
[38] Brazier and Cave (n 36), 271.
[39] In Part 1 of the Legal Aid, Sentencing and Punishment of Offenders Act 2010-2012 legal aid is eliminated for a wide range of cases, including most clinical negligence cases.
[40]Contravention of Article 6 of the European Convention of Human Rights is avoided by setting up an 'exceptional funding scheme', allowing exceptional funding for out of scope cases that will ensure that individual cases of this type continue to receive legal aid. Cave (n 29), 142.
[41] The Right Honourable Lord Justice Jackson, *Review of Civil Litigation Costs, Final Report,* (London: The Stationary Office, December 2009) Downloadable from www.judiciary.gov.uk. See details of restrictions on success fees uplifts and costs.
[42] Brahams (n 6), 1.
[43] Chapter 3 'Funding Litigation' above.
[44] Although claimants may indicate other motives, the redress available at the end of the day is financial. See Chapter 6 'Damages'.

the elements of liability. While proving the existence of a duty of care may not be difficult, the question of proving that the requisite standard of care was breached,[45] and then that the alleged breach caused the damage, is difficult.[46] With one notable exception,[47] the courts have been shown to be protective of the NHS budget[48] and not inclined to accept novel 'gist of the action' arguments such as 'loss of chance'. There is also the knotty question of who should pay. This was addressed above when I considered notions of corrective justice.[49] Suffice it to note here that there are times when claims can only be put right by the harm-doer, as when an apology is claimed. There are other circumstances, such as where the claim is for money, where this can then be satisfied by someone else, such as the insurer. I have briefly touched upon the way damages are calculated and paid. There has been a major change wrought with periodical payments in specific situations which makes damages payment less of a windfall or lottery. As always, there are winners and losers.[50]

The litigation route to redress, therefore, remains a first option only for claimants who can fund it, who have a good evidential basis for their claim,[51] can prove the liability elements and are seeking damages. A sum for non-pecuniary loss (pain, suffering and loss of amenity) will be an element of the damages received. My focus in this chapter is to consider alternatives to redress *non-pecuniary losses*.

3. Redress Within the NHS: Just Redress as it Stands?

We are a long way from providing the essential elements for a new just system for redress as rehearsed by the Ombudsman.[52] To summarise: this included timely provision for a full range of remedies for justified complaints, in particular: explanations, apologies, specific actions or treatment for the patient, changes to prevent recurrence

[45] The role and cost of expert witnesses was discussed in Chapter 4 'Proving Liability: Duty of Care and Breach of Duty'.
[46] Chapter 5 'Causation'. Particularly difficult in medical cases where there is a background risk factor already operating.
[47] *Chester v Afshar* [2004] UKHL 41 where judicial concern focused on the patient's human rights.
[48] *Wilsher v Essex AHA* [1988] AC 1074 remains good law.
[49] Chapter 1 'Corrective Justice and Entitlement to Redress within the NHS' above.
[50] See R A Buckley, *Buckley Law of Negligence & Nuisance* 5th edn (Part of the Butterworths Common Law Series) (London, Lexis Nexis UK, 2011), 674 regarding the arbitrariness of the current legal system for compensating tort victims.
[51] Particularly if funded through a conditional fee agreement. Chapter 3 'Funding Litigation.'
[52] Abraham (n 2), Chapter 3 'Key Elements of a New System'.

and, where appropriate, financial compensation.[53] In an ideal world, these elements would be addressed within one system.

I have discussed, *inter alia*: the failings of the regulatory system;[54] the difficulties aggrieved patients and their families may have in accessing NHS complaints processes; the failure to provide a coherent system for learning from complaints; and the myriad of complications arising from the lack of true dialogue between aggrieved patient and doctor. While there is good practice in parts of the NHS, the picture is not uniform and the status of complaint processes varies greatly amongst hospital Trusts. Curtailment of resources within the NHS will negatively affect attention to redress for past failings.

C. The Role of Apology in Addressing Non-Pecuniary Loss

Liability in negligence results in damages. Damages operate as compensation, as a marker of wrongdoing and as acknowledgment that redress is needed. Damages also address needs and many people regard this as the most significant aspect of damages. Damages are often seen as the central vehicle of corrective justice in the sense that they operate to redress the balance between the parties by correcting the loss suffered by one party at the expense of the other who caused it. If damages are only about need then a no-fault scheme could be a way to deal with loss.[55] Apologies, while doing some of this work, marking wrongdoing and offering acknowledgment, do not address need in the same way. Apologies can be part of the corrective justice mix if one considers compensation as practical reparation and apology as reparation for the emotional and moral pain suffered by the victim. I will argue that *full apologies* would redress some of the intangible aspects of loss following iatrogenic harm.[56]

[53] See Chapter 7 History of the NHS Complaints Processes: 'A Curate's Egg?' above for full discussion.
[54] The Care Quality Commission.
[55] H Luntz, 'Reform of the Law of Negligence: Wrong Questions – Wrong Answers' (2002) 8 *UNSWLJ Forum: Reform of the Law of Negligence: Balancing Costs and Community Expectations* 2, 18.
[56] Vines (n 10), 15.

III. FACILITATING EFFECTIVE REDRESS APOLOGIES AND NON-PECUNIARY LOSS

A. Setting the Scene: Trust

Trust is at the heart of all medical decisions.[57]

> The purpose of healthcare law and policy must be to establish an environment in which trust thrives. Trust is the primary value for the relationship between patient and healthcare professional to work. .[58]

I am considering the issue of apologies in the context of private law[59] in the sphere of clinical negligence. There are special elements in the medico-legal field that merit mention. Trust is crucial in the medical setting yet involves the patient in deciding whether or not to take the inherent risk. Some will trust because they have dealt with the doctor before; others will trust because of the reputation of the doctor; still others will trust because they believe the healthcare system they are entering is one that can be trusted, in this case the NHS. At present, trust, as the basis for the relationship between healthcare professional and patient, is being replaced by the rules, practices and processes of systems. Yet those rules, practices and processes cannot do the thinking and problem-solving necessary to diagnose and treat a particular patient.[60] The judgement involved is an art, a human skill which the patient has to trust. Mistakes are a reality of the complexity of the healthcare world and the possibility of mistakes must be part of the expectations discussed in the patient-doctor relationship. Healthcare professionals need to be open about their mistakes and share those with other professionals and patients to avoid their repetition.[61]

What militates against good communication and wholehearted openness regarding adverse events? One key to understanding communication difficulties is to appreciate the inherent power imbalance between the patient and the doctor. At the fraught time of

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[57] M Henaghan, *Health Professionals and Trust: The Cure for Healthcare Law and Policy* (London, Routledge, 2012), 2.
[58] Ibid at 12.I use the phrase 'healthcare professional' and 'doctor' interchangeably.
[59] In contrast with apologies in the public sphere of governments. See M Nobles, *The Politics of Official Apologies* (Cambridge, Cambridge University Press, 2008) and N Smith, *I Was Wrong: The Meanings of Apologies* (Cambridge, Cambridge University Press, 2008).
[60] See Henaghan (n 57), 6 for discussion of the undermining of trust by audit: compliance for compliance sake.
[61] Ibid at 20.

the realisation of iatrogenic harm, families want understanding and to be heard. What they need most is knowledge – they need full disclosure of the mistake made and an apology for it with the offer of fair compensation.[62] Although it is a fundamental ethical requirement[63] that a physician should at all times deal openly and honestly with patients, the physician may perceive himself as all-knowing and prefer to see what has happened as a 'complication' rather than confront his own limitations. The combination of an all-knowing doctor, whose identity is synonymous with his/her status, and the patient and the family who want to know what really happened, creates a major trust gap between the two groups.[64] Another crucial factor which colours all these transactions is the difficulty of real communication. In my discussion of 'open disclosure' I highlighted the complexity of imparting[65] and hearing information.[66] One of the major goals of *full apology* is the restoration of the relationship between doctor and patient.[67]

It is against this contextual background of the issue of trust that I will discuss the role apology might play in providing some redress for the pain and suffering of 'not knowing' and the need for acknowledgement of wrong and undertakings to repair. I will discuss and analyse the definition of apologies, their function and limitations, apology-protection legislation, and the supposed effect apologies might have on litigation. I conclude with arguments for their place as a compensatory aspect[68] of offering effective redress for the non-pecuniary aspects of iatrogenic harm in the NHS.

B. Apologies: Timing and Definition

> Reconciliation means the healing of the relationship - an apology (and possible reparation) on the one side and forgiveness on the other creating the healing. Thus, an apology may not be an end in itself, but part of a larger sequence.[69]

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[62] N Berlinger, *After Harm: Medical Error and the Ethics of Forgiveness,* (Baltimore, Hopkins University Press, 2005), 38-39.
[63] American Medical Association, 'Opinion 8.12 –Patient Information' *Code of Medical Ethics,* March 1981.
[64] Berlinger (n 62), 41.
[65] Chapter 2 'What Patients Seek from Redress' above: ie what and how much information is imparted and how is it understood?
[66] See NC Manson and O O'Neill, *Rethinking Informed Consent in Bioethics*, (Cambridge, Cambridge University Press, 2007) for analysis of the limits of informed consent and the nuances of *communication transactions.*
[67] Vines (n 10), 5.
[68] Vines (n 7), 499.
[69] Vines (n 10), 1.

1. Timing

Justice delayed is justice denied.[70] Starting from a premise of doing no harm, then harm being done, creates an obligation to rectify that harm. The first way to do that is to be honest with the patient as to why and how the harm has occurred. I see the full apology as the beginning of the process of redress, therefore to be given before any clinical negligence litigation. It is only when the patient is fully apprised that he can make an informed choice of how to proceed: whether through the complaints procedure, litigation or no further action.[71] This goes some way towards equalising the power differential between the parties. Delaying the giving of an apology involves costs to the patient.

The longer the process goes on, the more deeply the grievance sets in. There is also the psychological cost to the patient and/or family of living with the possibility of no resolution. While the matter is unresolved, the anxiety caused by it means that people, patient as well as doctor, do not function at the levels they are capable of. These are, *inter alia*, the costs in not addressing the problem so that it can be dealt with in a way that makes it less likely to happen again.[72]

2. Full Apologies, Partial Apologies and Forgiveness: What Do We Mean?

> Defining apologies is crucial to determining their function. Apologies have multiple functions, one of which is corrective justice.[73]

There is such a thing as a true apology, called a full apology, and whether public or private, an apology is not real unless it includes an acknowledgement of fault. What is apologised for is a wrong rather than a loss because the moral question to which apology responds is whether there has been a wrong.[74] A full apology does not exist unless the person who is expressing regret is also taking responsibility for a wrong which they have committed. This definition applies whether considering an apology from a moral theory point of view or from a psychological point of view.[75] *Partial apologies* are known as 'safe' apologies because where there is no acknowledgment of

[70] Henaghan (n 57), 75.
[71] Teninbaum (n 27), 34: a prompt apology gives patients an opportunity to consider their options.
[72] Ibid.
[73] Vines (n 10), 1.
[74] Apologies in the civil liability area are to be viewed as a form of corrective justice. Ibid at 8-13.
[75] Ibid at 5 fn 21 and 22.

fault, there is no risk of legal liability. Saying 'I am sorry' is defined as a mere expression of regret or a *partial apology.* This might operate as a soothing device for small hurts or where the person speaking has no responsibility.[76] As discussed below, much of the legislation which protects apologies only protects this type. *Forgiveness* by the victim is the other side of the sequence leading to reconciliation. Forgiveness involves the suspension of hostile feelings towards the wrongdoer. It fosters reconciliation and the restoration of relationships. Finally, forgiveness involves the removal of the guilt created by the wrong – in other words completes the sequence of wiping the slate clean. Realistically, I think this is an outcome which can only be partially achieved.[77]

As Prue Vines points out in her writings, the concept of apologies in this sphere was born out of apologies in the public arena in relation to governmental actions relating to war or treatment of indigenous people or other matters. One reason for hesitancy by governments is that an apology may require compensation. However, in Australia, the argument for apologising to indigenous people is seen as part of reconciliation.[78] In the civil arena apologies are seen as a norm with specific functions.[79] The positive side of full apologies offers doctor and patient face-to-face communication essential for corrective justice. It is a chance for a full explanation of the adverse event, the acknowledgement of fault and the acceptance of responsibility. Apologies can also create meaning for people out of events which can otherwise seem utterly meaningless. Finally, apologies may dissipate anger in a way which is related to the severity of the harm, and reduce aggression.[80]

3. The Consequences of Offering Partial or Insincere Apologies

There are consequences attendant upon offering less than full apologies. As noted in my discussion of the communication difficulties in imparting information, apologies, since they are mediated by language, entail an extremely complex, highly nuanced process. Literature from Canada concurs that 'disclosing medical errors to patients may sound

[76] A mere expression of regret is a partial apology. Ibid at 5.
[77] Ibid.
[78] Ibid at 4.
[79] N Tauchis, *Mea Culpa: A Sociology of Apology and Reconciliation* (Stanford, Stanford University Press, 1991), 39.
[80] Vines (n 10), 10.

straightforward; however, it is actually a very challenging communication task'.[81] The conceptual and moral problem with an apology is whether or not it is sincere. There are significant risks in giving apologies which are perceived as insincere. Such apologies may actually release further aggression.[82] In addition, relationships between patients and doctors are not healed by such an apology; if anything they are made worse and further compromise trust.[83]

I have defined the requisite ingredients and potential reparative work that full apologies can offer. Yet these apologies are rarely forthcoming. Despite the fact that in the UK a number of high profile cases have highlighted the problem of non-disclosure to patients of adverse events in medical care, the push for a mandatory disclosure law has not yet materialised.[84] I now turn to the question of the effect on apologies of apology-protecting legislation.[85]

C. Apology-Protecting Legislation: Apologies, Insurance and Liability

1. Why Sorry is the Hardest Word

Hindering the practice of offering full apology has been the interpretation of the frequent clauses in insurance contracts which void the contract if any admission of liability is made.[86] These clauses, known as admissions and compromise clauses, are the driving force behind organisations advising clients not to apologise because an apology may be taken as an admission of liability. In order to facilitate apologies and address the fear of litigation, apology-protection legislation has been passed in some US jurisdictions since 1986, in Australian jurisdictions since 2002 and Canada[87] and the UK since 2006.[88]

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[81] Levinson and Gallagher (n 26), 266.
[82] Vines (n 1).
[83] Henaghan (n 57), 72-73.
[84] Vines (n 1).
[85] Where appropriate I will analyse reforms in Australia and the United States (US).
[86] See Vines (n 7), 487 for full discussion and examples of how the courts have dealt with the problem.
[87] British Colombia *Apology Act* RSBC 2006, Bill 16 makes an apology for an adverse event inadmissible for the purposes of proving liability. Levinson and Gallagher (n 26), 266.
[88] Massachusetts General Laws TiT II Ch 333, s 23D; Civil Liability Act 2002 s 68 (NSW); Civil Law (Wrongs) Act 2002 (ACT); British Colombia Apology Act (n 87) and UK Compensation Act 2006 s 2 'An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty'. The UK legislation is unsatisfactory as there is no definition of apology. Vines (n 1).

The vast majority of legislation in the US is legislation specifically directed at medical negligence litigation; elsewhere the legislation is directed at civil liability in general, or in relation to personal injury in general. The concern that an apology may amount to an admission and therefore directly or indirectly create liability is a legitimate one. In the UK, the explanatory note to the Compensation Act 2006 asserts that the answer to the question of whether an apology is an admission of liability is *no*. However, it is not simply the case that any kind of apologetic utterance will not amount to an admission of liability creating or going to liability. It appears in England, Wales and Scotland that the law states that an apology 'of itself will not amount to an admission of liability, particularly in relation to negligence law. This is because liability is a legal conclusion which courts will always have to draw themselves. However, as the case law is equivocal, there cannot be complete confidence about the position.[89]

In Australia there have been cases that have made it clear that the fact that someone has said it is his or her fault does not mean s/he is automatically liable for an injury. All Australian jurisdictions since 2002 have passed legislation which prevents an apology from being deemed an admission, from being admitted into court and from determining liability. The aim of the legislation was to reduce litigation by protecting apologies. It is clear that the courts regard it as their prerogative to determine liability. If an apology does not determine liability then it should not void an insurance policy. Nonetheless, there are difficulties, at present, for Australian medical practitioners and for the open disclosure process.[90] The Acts in different jurisdictions do not define apology in the same way. New South Wales, the Australian Capital Territory and Queensland define apology as including an acknowledgment of fault (full apology). The other States and the NT define the apology that is protected by law as merely an expression of regret (partial apology). This creates a serious problem for three reasons.

One, as noted above, is that research shows that most people regard an apology as real only if it includes acknowledgement of fault. Partial apologies can elicit increased anger. The second reason is that in a country where businesses, including insurance companies and projects such as *open disclosure*[91] are national, the fact that there are differences

[89] Space precludes case discussion and evidential considerations. See P Vines 'Apologies and Civil Liability in England, Wales and Scotland: The View from Elsewhere' (2007) *University of New South Wales Faculty of Law Research Series* Paper 61 (online at bepress Legal Repository) at 15.
[90] P Vines, 'Sorry Saga of Apologies' December 2011 at *www.mjainsight.com.au/view?*
[91] RAM Iedema et al, 'The National Open Disclosure Pilot: Evaluation of a Policy Implementation Initiative' (2008) 188 *Medical Journal of Australia* 7, 397- 400.

across the States and Territories causes unnecessary confusion. And, unfortunately, in most cases, for the sake of uniformity, advice will be based on the lowest common denominator, namely the partial apology. Therefore, even when a doctor is working in NSW, a jurisdiction where full apology is protected, he is likely to be told by open disclosure trainers to give only a partial one. The third problem for practitioners is that they are told there are strict parameters about how to apologise which make apologies even harder to make sincerely.[92] Vines finds this disappointing because there are, as I will discuss below, several hospitals in the US and Australia that have moved to a system of full disclosure – including acknowledgement of responsibility for harm – which have found their litigation bills declining. Vines' recommendations for facilitating protected apologies are: education of lawyers, medical practitioners and insurers;[93] a change to the definition of apology to include acknowledgement of fault in all jurisdictions; and finally the creation of uniform legislation.[94] I agree that there is much of value in legislative protection of apologies and it helps to avoid the 'chill factor' of lawyers and insurance companies advising doctors not to apologise. The main impetus for creating apology-protecting legislation was the assumption that litigation would be reduced, thereby saving costs to both defendants (for present purposes the NHS) and insurers.

Concern about whether disclosing medical errors increases malpractice claims has been one of the main barriers to disclosure. However, the relative effects of disclosure versus compensation on the outcome of litigation is not possible to assess and the research is not definitive; there is emerging evidence that the number of malpractice claims may either stay the same or decrease after implementation of open disclosure policies accompanied by financial compensation in appropriate cases.[95] Overall, however, the evidence to date is inconclusive.[96]

2. The Effect of Apologies on Litigation

As I have argued, full apologies have much to offer, but this does not mean that nobody sues. In many cases, particularly in the US and other countries including the UK, where

[92] P Vines (n 90).
[93] The need for training programmes to facilitate high-quality disclosure is echoed in the Canadian literature. Levinson and Gallagher (n 26), 266.
[94] Vines (n 1).
[95] Levinson and Gallagher (n 26), 266.
[96] Vines (n 90).

social security payments are low, a badly injured person may need to sue in order to get sufficient money for his or her consequent treatment and care. Nevertheless, it may be that patients who have been subject to adverse events and subsequently receive a full apology are more likely either not to sue or to settle their cases before trial.[97] In settling a case, costs are reduced.[98]

My argument is that it would be helpful to consider initiatives in the US, Canada and Australia offering open disclosure and full apologies.[99] That said, open disclosure and full apologies (which depend upon open disclosure) are not easy options.

D. The Other Side of the Coin: How Medical Apology Programs Harm Patients

I have included the following material because in the concerns expressed about the lack of independent advice to claimants there are echoes of the NHS Redress Act 2006[100] provisions, eschewing independent legal advice to patients. The Welsh program also compromises independent review of the adverse event.[101]

When a lawyer suspects that he has committed legal malpractice, he must disclose it to the client and recommend that the client seek outside counsel to get objective legal advice on how to proceed. By contrast, when a doctor suspects that he has committed medical malpractice, at many facilities he is expected to employ a set of protocols that discourage the injured patient from considering the need for compensation. Yet, while a lawyer could be disbarred for this sort of behaviour, medical apology programmes receive praise.[102] In an interesting and detailed paper, Gabriel Teninbaum does not reject full apologies *per se* but is critical of the way in which they are used in medical apology programmes. His contention is that their design subverts the goals of fully compensating patients under the principles of tort law. Injured patients are manipulated as a means to persuade them not to pursue monetary damages. He argues that modern

[97] Space has precluded discussion regarding resolution by mediation but no doubt a full apology would assist that process also.
[98] Vines (n 10), 15.
[99] Iedema (n 91), 397- 400 and Vines (n 10), 1.
[100] Chapter 8 'NHS Redress Act 2006 – A Lost Opportunity' above. See NHS Redress Act 2006 s 8 'independent advice only offered in relation to offer and any settlement agreement'.
[101] Lewis and Buchan (n 13), 560.
[102] Teninbaum (n 27), 2.

apology programmes appear to *cool their marks*.[103] In other words a person in power uses persuasive methods to control the emotional state of the mark (ie the patient); the intended effect diffuses the mark's righteous anger to the benefit of the perpetrator. These programmes[104] appear to *cool their marks out*[105] as a means of preventing them from speaking to a lawyer and becoming educated about their rights.[106]

For present purposes, what is significant about the contrasted studies of medical apology programmes are their provisions for the patient's access to independent legal advice. The Lexington Veterans Affairs Medical Centre[107] model was the last publicised programme in the US that included the need to advise unrepresented patients who are malpractice victims[108] to bring an attorney to negotiate on their behalf. Surprisingly, in a subsequent study, data indicated that disclosing errors in specific ways may not result in an increase in malpractice claims or in the amount paid per claim.[109]

However, further studies supported the idea that many patients were willing to accept a fraction of the amount of money they would get in a malpractice suit if the doctor simply apologised.[110] The rules pertaining to COPIC, (a primary insurer for Colorado's 3 Rs programme: Recognise, Respond, Resolve)[111] range from not allowing attorney involvement to refusing to allow a patient who has written a letter from participating. In addition, this compromises practitioner accountability and potentially harms future patients.[112] The University of Michigan Healthcare Model[113] created a system designed to address the issue patients want resolved: explanation and holding the doctor to account. Unlike COPIC, UMHM allows patients to seek legal advice but does not do so routinely. The criticism of this programme is that there is no protection for patients against the conflict of interest which arises, as UMHM is a self-insured facility. The

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[103] Erving Goffman, 'On Cooling the Mark Out: Some Aspects of Adaptation to Failure', (1952) 15 *Psychiatry* 451, 455.
[104] The Lexington VA Medical Center (hereinafter Lexington), COPIC (a primary insurer for Colorado's 3 Rs program: Recognise, Respond, Resolve) which works with monetary caps (hereinafter COPIC) and the University of Michigan Healthcare model (hereinafter UMHM) in Teninbaum (n 27), 12.
[105] Confidence men use a tried-and-true set of techniques to convince (or cool out) their victim (or mark) not to complain after he has been swindled. Teninbaum (n 27), 3.
[106] Teninbaum (n 27), 3.
[107] Lexington (n 104).
[108] Teninbaum (n 27), 8 fn 21.
[109] Ibid, 8.
[110] Ibid Part IV at 26 fn 127. 'If Everyone is Happy, What's Wrong?' See also RE Quinn & MC Eichler, 'The
3Rs Program: The Colorado Experience' (2008) 51 *Clinical Obstetrics & Gynecology* 709, 710.
[111] COPIC (n 104).
[112] Teninbaum (n 27), 15.
[113] UMHM (n 104).

author concludes with a plea for empowering patients to know their rights in order to make informed decisions about seeking redress.

IV. EFFECTIVE REDRESS

A. Can Complaints Programmes Become a Way to Build Trust? The New Zealand Experience

In New Zealand, compensation is paid through the Accident Compensation Act 2001, whereby the loss is spread across all employers by way of a levy.[114] A hospital could show its repentance by acting quickly to minimise the damage. Compensation is financial, but repentance also requires actions by those involved: it may be by providing extra care; helping with chores in the house; listening to the injured person and working with them to put into place processes which will avoid a repetition of the adverse event. Disclosure of what happened to them and a timely apology would go some way to beginning resolution. I appreciate that New Zealand operates a no-fault system[115] to deal with medical accidents, but the necessary ingredients for a humane and efficient redress system remain constant.

In the New Zealand context, fair compensation would be covered by the Accident Compensation Act 2001 and could include rehabilitation costs, income compensation, lump sum compensation, funeral costs, survivors' grants and spousal compensation. Mark Henaghan argues against large sum payments for loss of life barring those cases where there was dependency. He argues that the existence of the threat of large financial compensation for non-pecuniary loss and Draconian professional penalties act as a deterrent, making disclosure and apology less likely. I have alluded to the pitfalls of delay and the psychological toll on both parties. A key feature for fairness to all concerned is the crucial availability of an independent third party to investigate and assess the complaint straight away. If it is found that there is no basis to the complaint, it should be dismissed immediately, thereby leaving no opportunity for uncertainty and stress to fester. Tact, confidentiality for both sides, and careful use of language are essential. As noted above, the lack of independent review bedevilled the proposed Redress Act 2008 and the Welsh project. As in the UK, complaints may be referred to

[114] See Henaghan (n 57), 74-75 for full exposition of these ideas.
[115] This looks more like distributive justice as more victims are paid smaller sums. I am concentrating on the content and joined-up aspect of the compensation process.

the Health and Disability Ombudsman, who has similar powers to our Ombudsman. In New Zealand, as here, the Ombudsman's office is overstretched.[116]

I believe that, excepting the necessary compensation, the most important trust-building and useful outcome from a medical redress system is the undertaking to repair. I have noted how important to all victims it is that something should be learnt from the adverse event to ensure that others do not suffer the same fate. Examples of good practice would be the repackaging of the chemotherapy drug Vincristine[117] and the new World Health Organisation surgical checklist.[118]

I have listed herein the requirements for a just redress system for iatrogenic harm. How this is to be delivered in the UK remains a challenge. On the present horizon is the prospect of a new small claims process with higher limits and adaptations for clinical negligence requirements.[119]

V. CONCLUSIONS

In this final chapter I have reviewed the legal and NHS systems in place for redress for iatrogenic harm in England. Relying on corrective justice principles which place the relationship between victim and tortfeasor foremost, I have analysed and advocated as a first step – before an action for clinical negligence – the timely giving of full apologies where appropriate. I have noted the importance of trust for the patient, doctor and the NHS system. I then introduced the topic of apologies, their definition, function and limitations when used inappropriately. I then analysed the apology-protection legislation and the presumed though inconclusive effect apologies may have on litigation. I have argued that, despite potential pitfalls, full apologies have a significant role in addressing redress for the non-pecuniary aspects of iatrogenic harm.

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[116] Henaghan (n 57), 76.
[117] After the negligent death of Wayne Jowett (2001). See *The Guardian* 20 April 2001 and 16 August 2011 for follow-up.
[118] See Henaghan (n 57), 79-81 for full exposition of making hospital environments safer.
[119] 'RTA portal struggles with claim numbers as clinical negligence pilot is set for April' (28 July 2011) Legal Futures contains the following quotation: 'On clinical negligence, Justice Minister Jonathan Djanogly told Parliament recently (2011) that the Ministry of Justice is working with the NHS Litigation Authority and claimant lawyer representatives to devise a pilot for dealing with cases valued between £1,000 and £25,000.'. Online at http://www.legalfutures.co.uk/news/rta-portal-struggles-with-claim-numbers-as-clin-neg-pilot-is-set-for-april

CONCLUSIONS

> Cynics beware, I am romantic about the National Health Service; I love it. All I need to do to rediscover the romance is to look at the healthcare in my own country.[120]
>
> The Government have announced that they intend to establish a comprehensive health service for everybody in this country. They want to ensure that every man, woman and child can rely on getting all the advice and treatment care which they may need in matters of personal health.[121]

[120] DM Berwick (President, Institute for Healthcare Improvement, Cambridge Mass. USA) 'A Transatlantic Review of the NHS' (2008) *British Medical Journal* 2008; 337; a838. Paper given at the NHS Live conference celebrating 60 years of the NHS, July 2008.

[121] Ministry of Health, Department of Health for Scotland. *A National Health Service* (Cmd 6502). (London, HMSO, 1944) in T Delamothe, 'NHS at 60: A Comprehensive Service' (2008) *British Medical Journal* 336: 1344-1345.

FINAL CONCLUSIONS

The thesis has addressed how effectively or otherwise the civil justice system – through litigation and/or the NHS complaints procedures – provides redress for patients suffering iatrogenic harm in the course of treatment received under the aegis of the NHS. In the case of iatrogenic harm, sadly, the victim often cannot be put back into his pre-tortious state. It nevertheless must be possible to have more meaningful redress than is presently on offer.

I have assumed that the NHS is a public good that should be supported. The competing tensions in my argument are around doing justice to iatrogenically harmed patients while at the same time protecting a limited budget devoted to treatment of the population at large. The best solution would be a reduction of adverse events but, for present purposes, I concentrate on effective redress for past adverse events.[122]

I have premised the obligation for victims of iatrogenic harm to be compensated upon corrective justice principles,[123] constrained by notions of distributive justice when it comes to paying damages from an overstretched NHS budget. Patients' wishes for restoration, correction, communication, sanction and financial support, where appropriate, should be attended to.[124] There is a place for financial compensation for pecuniary loss and this is achievable through litigation.[125] I have noted that the route to damages has many practical difficulties, including the funding of litigation[126] and proving liability,[127] but although payment of money as compensation for pecuniary loss[128] can never be a like-for-like substitution, it can be said to be a congruent redress. I remain of the opinion that non-pecuniary loss should be compensated by means other than damages, not solely because of NHS budgetary constraints but because other redress would more effectively address these needs.

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[122] I have delineated the details both in the body of the thesis and in the final Chapter 9: 'Effective Redress and the Role of Apologies.' Here I summarise only.
[123] Chapter 1 'Corrective Justice and Entitlement to Redress within the NHS' above.
[124] Chapter 2 'What Patients Seek from Redress' above.
[125] Part II Medical Negligence Litigation, above.
[126] Chapter 3 'Funding Litigation' above.
[127] Chapters 4 'Proving Clinical Negligence: Duty and Breach'; Chapter 5 'Causation' above.
[128] Chapter 5 'Damages' above.

I have considered redress for non-pecuniary loss within the NHS, namely, the complaints procedure[129] and the Redress Act 2006.[130] The former was found wanting in all aspects: not timely, explanations not forthcoming, no system for learning from mistakes. The latter Act has never been fully enacted. A major stumbling block for patients and their families who suspect iatrogenic harm is lack of information. This difficulty affects both the civil justice system and the NHS complaints processes. Information is power and the withholding of that information reinforces the power differential between the doctor/healthcare provider and the patient. Access to just redress depends upon the patient making an informed decision about how to proceed to claim his need for and/or right to redress. The innovative work on *full apologies* with *apology-protecting legislation* in common law countries offers a way forward which would re-establish trust and empower patients.

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[129] Part III Redress within the NHS; Chapter 7 'History of the NHS Complaints Process – A Curate's Egg?' above.
[130] Chapter 8 'The NHS Redress Act 2006 – A lost opportunity?

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